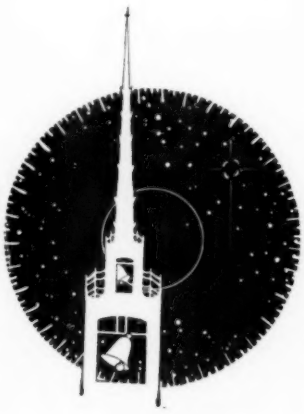
PUBLIC HEALTH NURSING

Official Organ of the National Organization for Public Health Nursing, Inc.

Christmas 1939



SO MUCH CHANGE has taken place in this troubled world since our last exchange of Christmas greetings, that it is with difficulty we realize another cycle of time has spent itself.

As we view ourselves in relation to the chaos about us, we must be impressed with our great and good fortune. While so many others are still without occupation, our services are increasingly in demand. While others grope in uncertainty, we have our well tried, constantly improved tools and patterns, underwritten by our National Organization for Public Health Nursing, which give us security. While others reach for a satisfying experience and a satisfying philosophy, we find both at hand in our daily work. These are great gifts—and they imply obligation. We meet this obligation by a daily reconsecration to sincere, thoughtful, and efficient public service, a like service to all regardless of race, nationality, or creed. We have learned that through generous service to all who need it, we can find that peace which is so beautifully heralded at this season.

May it be with each of us in generous measure throughout the New Year.

GRACE ROSS, *President*
National Organization for Public Health Nursing

TWO STAMPS ON CHRISTMAS CARDS

AS long as many of us can remember we have put two stamps on our Christmas mail, one required by Uncle Sam, the other voluntarily purchased and used by us to promote the fight against tuberculosis—the Christmas Seal with the double-barred cross. The history of the seal reads like a Bob Ripley "believe it or not" story. That millions and millions of colored bits of paper, worthless in themselves, should have saved millions of dollars in human lives and restored health and happiness to thousands of families is very nearly a modern miracle. The little lady (Emily Bissell) who conceived the idea of the seal should, we believe, some day have her own picture on the seal in honor of her contribution to the movement.

Public health nurses probably have more real understanding of what adequate funds can do in the control of tuberculosis than has any other group of health workers. They actually meet with the limitations and in many cases must solve the problems arising out of meager facilities and resources. Public health nurses know how often children in a family are infected by the delayed admission of the infected parent to the hospital. They know how the lack of available clinic facilities at reasonable cost encourages postponement of examination and care. They know how the scarcity of public health nurses in the rural areas reduces case-finding and follow up. Even such simple provisions for good clinic service as comfortable, homelike rooms, up-to-date equipment, and adequate files and records often call for more money than local groups can supply.

Public health nurses also know best the effect of tuberculosis on the personal lives of individuals and families—the curtailment to the promising career of the young person, the removal of the wage earner, the breakup of the family circle due to the illness of the mother, the long, long road to recovery which tests everyone's courage and patience. Nurses know these things at first hand, and probably as we stick our Christmas seals on Christmas packages some recent case comes vividly to mind and the seal goes on with more than ordinary symbolism. Let us not, however, think of the seal as a dreary symbol of existing cases but rather in its higher purpose of prevention. As such it does have a place with the cheery red, green, and silver decorations of Christmas and can carry its own message of hope and glad tidings.

D.D.

Maternity Care in the Home

By LILLIAN JEFFERS, R.N.

Good maternity nursing involves accurate scientific knowledge, adaptability to the needs of the individual patient, and utilization of teaching opportunities

SOME TWENTY years ago when the first bill providing for federal aid to states in preserving mother and child health was being debated in Congress, an eminent senator stormed: "Shall the Government, for the first time in America, enter the home, thrust its official nose into family affairs, and assert a right of interference in the holiest, tenderest, most tragic thing that ever occurs upon this earth—the birth of a child?"*

This attitude was not uncommon those few decades ago. Today, the need for skilled medical and nursing supervision throughout the maternity cycle is generally recognized. Facilities for care, both private and governmental, have been widely extended, and medical and nursing education in maternity practice has been greatly improved. Our problems today are of a different nature.

The important thing to be considered about maternity care today is that not enough people know what it is in all its elements and not enough people are putting into practice what they do know. This is as true of nurses as it is of doctors and laymen. Yet, if there is one field in nursing that demands a combination of knowledge, skill, and common sense, it is the maternity field. There are nurses in this field who are precise technicians, proper in following fixed routines. There are others with less knowledge of the processes of pregnancy but with a more elastic understanding of the patient and her environment. There are all too few who are a combination of the two; yet it is the well rounded person who knows how to correlate her information—who makes the best maternity nurse.

The public health nurse is recognized as an integral factor in any program for maternal care. Her peculiar value as an interpreter and teacher, and her ability to give skilled, comforting bedside care, have given her a distinctive place in well rounded, progressive work. They have also given her a responsibility, for both the medical profession and the public have come to depend upon her to win the intelligent cooperation of the patient and to give protective care in the home. Upon the character and ability of the nurse depends much of the success of the maternity program.

Not every nurse can be made into a good nurse for maternity work, any more than every nurse can be made into a good surgical nurse. But with sound teaching and qualified supervisory service, more nurses able to do good maternity work can be developed. The reason we do not have them in the needed numbers today is that not enough of our instructors and supervisors know maternity work in all its aspects.

What are some of these aspects? We

* Congressional Record, Vol. 61, Part 9, p. 8767.

begin, naturally, with our antepartum work. Years ago the public health nurse confined her supervision to three major points—getting the patient under immediate medical supervision, obtaining regular urinalysis, and providing layettes. Steadily since then there has been developed an excellent and effective service that takes first rank in public health nursing. The report of the 1934 survey of public health nursing states:

> Prenatal care, although classified as an instructive service, ranks first [in public health nursing], even higher than bedside care and distinctly higher than all other instructive services. On the other hand, health supervision for school children ranks lowest of all services. . . . These two extremes tempt one to speculate on possible reasons. The content of the prenatal visit has been so definitely defined that it can easily be learned by the nurse, no matter what her experience in prenatal care may have been as an undergraduate student. A prenatal visit not only involves definite points of instruction and observation for specific periods during pregnancy but may also include such specific techniques as making urinalysis and taking blood pressure.*

This raises an important question. Are we not letting this system of routines dominate us too much? Are we allowing our adherence to fixed ways to keep us from learning how to individualize our care, to understand and treat the thousand and one variations in patient reaction and patient needs? Many agencies have a set schedule for nurses' visits to the patients' homes. A certain formula must be followed on each of these visits, though in some agencies the nurse is allowed to exercise her discretion to a certain degree. The writer's conclusion, after long observation, is that a fixed schedule of visits with a definite formula of action is a handicap to sound work. They circumscribe the good nurse and make an automaton of the mediocre one. Routines of some kind are necessary for the protection of both patient and agency, but the more the nurse knows about obstetrics and the closer she works with her doctors, the more such routines can be minimized.

The frequency and content of the nurse's visit should be determined by several factors. First of these are the doctor's findings and recommendations. It is as important for the nurse to know what the doctor has found and prescribed as it is for her to do one single thing in the home. In theory, we state there must be rapport between doctor and nurse. In practice, we often find antagonism between them. Perhaps some of this antagonism is due to the nurse's compulsion to stick to the routines.

Every doctor has his own methods of diagnosing and treating maternity. He is held responsible by the state and by his own conscience for determining what the patient needs. The nurse may not always see eye to eye with him, but her job is to do the best she can in helping him help the patient. If he has taken blood pressure, made tests and found the patient's condition satisfactory this week, why should the nurse routinely go over any of this territory again next week, unless there are new indications or symptoms? The nurse who knows her job knows what the doctor has done. She does not duplicate. She also knows the meaning of feet newly swollen, of the persistent headache, and of the dozen other things that warn of abnormality.

ADAPT TEACHING TO NEEDS

The intelligent nurse, the one who plans and thinks, knows that the quality of her visits is more important than the quantity of them. Most women are keenly interested in knowing what to expect during pregnancy, labor, and the postpartum period. Some of them are much further advanced in this knowledge than others. They have learned a

* National Organization for Public Health Nursing. Survey of Public Health Nursing. The Commonwealth Fund, New York, 1934, pp. 36 and 37.

great deal at the doctor's office, the clinic, or the mothers' club, or from former pregnancies. Some women know almost nothing about maternity or have not the capacity to learn much. Still others are so distraught that the teaching must be of almost a kindergarten variety. Some women can absorb in one lesson what it takes another patient ten and even twenty lessons to understand. The pattern-minded and pattern-controlled nurse who tries to make one type of shoe fit these various kind of feet does not get very far. Neither does the nurse who has a set piece that must be spoken at regular intervals.

The nurse who knows her job lets her patient do a good deal of the talking, in the form of questions. The starting point with each patient is based on what that patient knows about maternity and on her ability to absorb further knowledge. The spacing and content of visits to the patient are determined by that patient's needs.

USE SIMPLE LANGUAGE

The real test of the nurse's knowledge of the elements of maternal care is reflected in the patient's activities and attitudes and those of the whole family. Occasionally a patient will submit blindly to instructions, but the average woman needs to know *why* rest, good diet, exercise, and medical supervision are important to her and to her baby. How does the baby develop *in utero?* How can the mother help him? What does her physical and mental hygiene have to do with the birth of a healthy child? The patient wants to keep on living, she wants to be well, and she wants a normal baby. The way in which the nurse answers her questions and explains things will be evident in the patient's coöperation, in her freedom from fears, and in her preparation for the event. The nurse may know the answers, but her teaching may be hampered by the vocabulary she uses. The writer heard a nurse say to a patient: "You must nurse your baby, for the colostrum he gets will help him get rid of his meconium." The woman had no idea what the nurse was talking about. The nurse who uses tangible procedures, such as the testing of urine or the assembling of supplies, as opportunities for dramatizing her instructions will usually get the best results.

HELP TO ALLAY PATIENT'S FEARS

Pregnant women are especially prone to fears, superstitions, and old wives' tales. Many patients expect a hard labor; some resent the coming of another child. We are recognizing more and more what a tremendous part emotions play in the successful or unsuccessful termination of a pregnancy. A nurse inadequately informed or unsure of her knowledge is not much help here. Her routines are of little aid. She must know what she is talking about or her information may be dangerous misinformation. The doctor helps to allay these fears when he knows about them but he depends upon the nurse to discover them, report them, and help in treating them.

Attention must always be given to the possibility of abnormalities. The average patient has a very inadequate knowledge in regard to her own symptoms. Slight bleeding, with or without pain, may seem trivial to her unless she has been taught the importance of immediately reporting any adverse symptoms. The nurse must not only know the possible unfavorable symptoms and their significance, but she must be able to teach the patient regarding them in such a way that instead of being afraid the patient has a new sense of security. The nurse must also be able to develop in the prospective father a sense of responsibility that may not have been there originally. Too often our own attitudes have helped the father continue in his belief that it is his wife

alone who is expecting the baby. The nurse is in a strategic position to help both parents-to-be develop an attitude of genuine welcome to the new arrival.

PREPARATION FOR DELIVERY

One phase of antepartum work that lends itself readily to routines is the preparation of home supplies for labor, delivery, and the puerperium. The patient is given a printed list and the thoughtful nurse helps her improvise, substitute, and eliminate nonessentials when the patient's purse demands economy. The patient who plans a hospital delivery must be told what to take to the hospital, when to go, and how to get there.

The doctor and nurse who have given good antepartum care have no needless worry when the patient's labor begins. The patient has been taught what to prepare and how to be ready. In New Orleans we have separate staffs for the antepartum and delivery services. The nurses on the delivery service have opportunities to observe patients whose instructions have been good and those whose instructions have been meager. They make two common comments. First, the work done by the nurses during the antepartum period is reflected almost as though in a mirror by the degree of the preparation—mental, physical, and environmental—found when the delivery nurse takes charge. The picture is so sharp that the preceding nurse has virtually left her signature over a poorly or well done record. Second, preparation of women whose home instructions have been augmented by mothers' club teaching rarely leaves anything to be desired.

Here, in the delivery of the patient, is the place where stern adherence to routines is essential. The principles of delivery routines remain the same, whether the water is boiled in a ten-cent pan or a two-dollar aluminum boiler. The sterile areas in a home delivery are small, but they must be as aseptic as those in the operating room. The clean area is, however, large. It includes not only the patient's room, but the patient herself, the doctor and nurse, and even the patient's family and any other persons present in the home. The patient with a cold or other infection must keep her hands at or above her hips. The doctor or nurse with an active cold or other infection should report off duty from delivery service. Any other person with an infection is barred from the room.

In setting up equipment, two points must be kept in mind: (1) the convenience of the doctor and nurse, (2) readiness for emergency. Ease in action in an emergency may spell the difference between life and death for the patient.

But adherence to routines alone is not enough. Regardless of careful planning, the nurse not infrequently finds herself alone, without a doctor, during some stage of the labor. In the hospital, medical service is always near at hand. In the home, the nurse who is alone with a patient in labor carries a heavy responsibility. If the nurse does not know the mechanism of labor, its possible complications, and the methods of treatment for these complications, the patient is not much safer than if she had a neighbor in attendance. When may the patient be given nourishment? When is it safe to let her walk about? How can the progress of labor be determined? What conditions demand the immediate summoning of a doctor if he is not present? How can a nurse give safe delivery care if she cannot answer these and other questions?

Finally, the nurse must be kind. No substitute has ever been found for kindness. And the woman in labor, isolated by her pain and her condition, is peculiarly in need of the understanding of another human being. The nurse's own attitude in that room, her

ability to impart confidence and a sense of relaxation, have a strong influence on the progress of the labor. Who but the woman who has experienced them can know the pain and terror of what seem to be interminable hours of labor?

Too, the nurse on a home delivery cannot ignore the patient's family. To the family every hour of labor is an hour too long. Unless the nurse takes the trouble to go out to them at intervals, and in friendly fashion endeavor to allay anxiety, they may become alarmed and discuss all sorts of plans for shortening the labor. These plans may involve a hasty trip to the hospital for the patient or a change of doctor and nurse. A single Sairey Gamp type of neighbor can, in a few moments with a nervous family, do a great deal of damage unless the nurse is interested in the family as well as the patient.

The question of whether the nurse shall remain with the patient in active labor after the doctor has made his examination and left the house is one that must be settled according to local policies. At one extreme of this situation there is the nurse who leaves when the doctor leaves. At the other extreme, there is the doctor who places the major responsibility for medical care during labor on the nurse. He does not come to examine or reëxamine his patient, but leaves to the nurse the task of deciding how long she can wait before calling him. We have instances where nurses are forced to deliver babies because the doctor was inaccessible or could not arrive on time.

What is the middle ground? It is not possible here to discuss the many facets of this problem. It is only reasonable to ask, however, that when the doctor leaves the patient who is in active labor in charge of a nurse, he keep himself within reach of instant summons and be ready to come when called. The nurse should not have the responsibility of delivering a patient, except in a truly unavoidable emergency, unless she has had midwifery training and it is clearly understood that that is her responsibility. The nurse is not medically prepared to care for medical emergencies, nor has she legal authority for the practice of obstetrics.

POSTPARTUM CARE

Bedside care of the postpartum patient includes certain indispensable routines for both baby and mother. Care of the breasts and perineum, palpitation of the fundus, checking and instruction on diet, elimination, exercises, and the baby's nursing—these are points in the daily routines. But the constantly changing physical picture makes the nurse's teaching anything but a routine affair. The uterus is going down. The breasts are filling up. The mother's diet is increased. The baby's cord is drying. His hunger is increasing. The picture changes almost by the hour. The nurse who thinks that postpartum care can be given "just as well by a neighbor" probably thinks of this care as a purely routine process. On the contrary, the postpartum period offers perhaps the most fruitful occasion for teaching in the whole maternity cycle, especially when actual care is given the patient and her child.

The patient and her family are particularly receptive to instructions at this time, for the actual presence in the home of the long expected baby focuses attention on him and his mother. The husband and the other relatives want the mother to get well and strong and the baby to get a fine start. The nurse's visit gives them a sense of security. At the same time, every move that is made by the nurse has new meaning and interest to the mother and to others in the family. During that period of personal service, the mother comes to look on the nurse as a friend as well as a skilled worker. She talks over with her the

things that trouble her—the physical ailments, habits, and handicaps of family members. A nurse who knows how to listen as well as to ask leading questions leaves the postpartum patient after ten days, having more information about the family situation than she could ordinarily get in many months.

Because of the great distances which many rural nurses must cover it is impossible for them to give frequent bedside care—if they are able to give any care at all—to their postpartum patients. Nevertheless, the returns on even one thoroughgoing visit in which care is given are so satisfactory that some sacrifice in making this visit is justified. It must be remembered, too, that this postpartum time may be the only vacation or rest period that the mother will have. Even one bedside visit will enhance the comfort of the mother and help make that vacation more comfortable and safe.

POSTPARTUM EXAMINATION

Maternal care should not be considered complete until the patient has had her postpartum examination and has been discharged by her physician. The time of the first postpartum examination will depend upon the policy of the physician, but the number of examinations will depend upon the physical condition of the patient. For many mothers, the maternity cycle ends after a few days of rest in bed; others return for the postpartum examination just to please the doctor or nurse; while too few realize the real significance of this examination. Success in interpreting the importance of the examination depends upon the nurse's knowledge and her ability to impart information, The patient must understand why the pelvic organs must be rechecked. She must realize that the findings of the physical examination will determine whether she is able to return to her normal activities at the present time.

In the care of the baby the nurse has the greatest opportunity and obligation. To the insensitive or inadequately prepared the new baby is only a miniature human being with many physical needs. The better equipped nurse, however, knows that the business of being born was a hard experience for him and that already he is a complex human being with deep feelings and instincts. Already he has had to make profound adjustments, and every day finds him adapting himself to new situations.

The public health nurse can by demonstration and by her own attitude help the parents to see the importance of early and correct care for the infant. As she gives care day by day she helps unravel the mystery which seems to surround the new baby. The mother learns that the child has a definite reaction to his surroundings and that these reactions are her responsibility. She understands why she must handle the baby gently, yet with firmness, never letting him lose his sense of balance; that the tone of her voice and kindness are far more important than riches; that regular nursing and sleeping habits not only promote his general health but also provide recreation and rest periods for her and eliminate confusion for the family. She learns, too, that clear eyes and skin, glossy hair, and good body mechanics are dependent on adequate nutrition, proper elimination, exercise, and fresh air; that specialists trained in caring for infants are probably available at a price which she can afford to pay. The parents begin to realize that no one set of rules can apply to every child, but that the growing infant is acquiring daily new skills and habits. They learn that it is within their power to direct his activities in such a manner that he will develop into a healthy, happy individual.

In summary: The nursing program in maternity is directly dependent upon

the nurse's knowledge of the subject and her method of presentation. The degree of success rests on the amount of cooperation between the medical and nursing professions. The nurse's ability to meet the needs of the individual patient is responsible, in no small degree, for the development of the maternity program. This service, whether specialized or generalized, is an excellent source of family health supervision.

Presented before the Nurses Section. The First American Congress on Obstetrics and Gynecology, Cleveland, Ohio, September 14, 1939.

EXAMINING OUR PROCEDURES

EVERY NURSE making a maternity visit should ask herself these questions:

1. What do I hope to accomplish by my visit to this patient?
2. Do I accomplish it when following a certain procedure?
3. Are such failures as occur chargeable to the procedure followed or are they inevitable in human relationships?
4. Is any given procedure subject to improvement through simplification, economy of time and effort, understanding of psychological factors, or common sense?

In spite of our knowledge of the need for early registration of patients and in spite of years of effort on our part, patients are still registering for care late in pregnancy. Should we not ask ourselves wherein we have failed to make our teaching effective?

In a study made by the Metropolitan Life Insurance Company of 5800 maternity cases cared for by visiting nurses in 4 months of 1937, it was found that 50 percent of the total delayed registration until the last trimester of their pregnancy. Forty-one percent of these patients were living in New York City, Long Island, and Westchester County, New York, where care of a high standard was available. The same figure of late registration in the Kips Bay-Yorkville health district in New York City was reported by the Maternity Center Association for as late as January 1939. In two surveys of public opinion in these districts it was found that seventy-five percent of the people participating in the survey knew that a woman should be under care by the time her third month of pregnancy begins.

We, as public health workers, must concentrate on the problem of translating this knowledge into action. Perhaps the first step in the solution is an analysis of our present procedures. Perhaps by subjecting them to the searching light of the critical viewpoint, we may find a way to future progress.

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Presented before the Nurses Section, The First American Congress on Obstetrics and Gynecology, Cleveland, Ohio, September 14, 1939.

Studying the Quality of Nursing Service

By MARGARET REID, R.N.

A report on a study by the Nursing Bureau of the Metropolitan Life Insurance Company on techniques for evaluating the service given by public health nurses

BACK IN THE DAYS when there was no exact definition, in terms of degrees, of freezing, cold, tepid, hot, blood heat, and boiling temperatures, the scientist Robert Boyle complained that the thermometers in use "show us no more than the relative coldness of the air, but leave us in the dark as to the positive degree thereof; whence we cannot communicate the idea of any such degree to another person."*

Supervisors in the field of public health nursing are in much the same predicament. While they can tell whether they like an individual nurse, and whether the nurse seems to be doing a good job, such an opinion is at best partly subjective. Lacking a recognized scale in public health nursing performance, they are in the dark as to the degree of excellence of a particular nurse's work, hence they "cannot communicate the idea of any such degree to another person." In other words, "excellent" may mean two entirely different things to two different supervisors.

Experience has proved the truth of this observation. During 1936 and early 1937, the Nursing Bureau of the Metropolitan Life Insurance Company Nursing Service studied ratings of certain staff nurses submitted by several supervisors. It found, in many instances, a striking difference of opinion in the evaluation of a particular nurse's performance. One supervisor, for example, thought that a certain nurse's work was quite satisfactory; another thought it was poor. Careful studies of ratings submitted by various supervisors indicated that one had a strong tendency to rate her nurses very high and another had a tendency to rate hers very low. Moreover, a study of the ratings indicated that they did not give a clear picture of the nurse and her performance.

*Bolton, Henry Carrington. Evolution of the Thermometer, 1592-1743. The Chemical Publishing Company, Easton, Pa., 1900. P. 43.

NEED FOR DEFINING RATINGS

Consideration of this problem by the supervisors as well as by a number of staff nurses finally resulted in the conviction that it was necessary to define the ratings "excellent," "good," "fair," and "poor" as applied to performance in public health nursing. There was no thought that such definitions could be mathematically exact. One cannot graduate a scale of human performance with the same precision that one can graduate a thermometer scale. On the other hand it ought to be possible to standardize various levels of performance with a reasonable degree of accuracy so that "excellent" or "good" or "fair" would mean the same thing to the supervisor, the nurse under observation, and other supervisors. Also it was thought that the exact definition of these levels of performance would help the nurse to maintain or improve her service to families. Moreover, the supervisors believed that an analysis of performance based on well defined standards would remove the undesirable personal element from evaluation.

The *results* of a nurse's ministrations and teaching are seldom immediately evident even to herself. Sometimes the highest skill and the most profound knowledge are impotent in a given situation. On the other hand, the infinite resource and sagacity of nature herself or just plain good luck may assure a happy ending in spite of blundering. But all forms of education would go out of business over night if it could not be assumed that with knowledge and skill the best results are obtained.

The purpose of the supervisory materials described here was to help the individual supervisor find out whether a public health nurse possessed the skills, knowledge, and methods which would bring the best possible results; and if not, how they could be acquired. Differences in innate abilities were taken into account. The materials were further designed to help each nurse improve her own performance and to reach her maximum possibilities for growth. In part they were suggested by an idea which was developed in 1931 in the Hamtramck Michigan Schools for evaluating teacher performance. It was thought that a similar method of evaluation might be applied to public health nurse performance.

JOB ANALYSIS FIRST STEP

The first step was to agree upon a job analysis or outline of the various aspects of a nurse's work. This was done by jotting down on paper all the different things that a nurse does, just as they came to mind. These items naturally grouped themselves under five essential headings or main aspects of work:

Nursing
Teaching
Recording
Administrative activities
Maintaining community relationships

Under each main aspect of the nurse's service were listed the essential factors contributing to it, arranged according to their relative importance. The outcome of this process was a job analysis of a staff nurse's work, of which an abbreviated outline is given here:

A STAFF NURSE'S WORK

Nursing

Practical procedures

Basic principles of treatments and nursing care
Comfort of patient
Organization of equipment and work areas
Skill (speed, efficiency)
Finish

Teaching

Recognition of social, economic, and health problems
Recognition of attitudes
Analysis of problems
Accuracy and development of subject matter
Principles and methods of teaching; types used and skill in their use
Results

Recording

Accuracy
Completeness: data, narrative statements
Conciseness
Legibility and neatness

Administrative Activities

Balancing of case load
Planning
Office management
Reports

Maintaining community relationships

Resources known and used
Relationships
Participation in community health programs

Under each contributing factor in this analysis were listed various important principles involved. The next step was to describe on four levels—A, B, C, and D—the application of these principles. Examples of how this was done follow:

NURSING

Basic principles of treatments and nursing care

A. Performance

The nurse applied all of the basic principles involved in all treatments.

B. Performance

The nurse applied all of the important basic principles involved in all treatments.

The less important principles were carelessly applied.

C. Performance

Many of the important principles were not applied. Most of the less important principles were not applied. Example: Asepsis was applied in one case and not in another.

D. Performance

None of the important principles were applied. Many or most of the less important principles were not applied.

Comfort of patient

A. Performance

The patient was made as comfortable as the demands of the treatments would permit. The bedding and covers were arranged in such a way that the patient was at ease during the treatments. In every instance, the temperature of the room, ventilation, and amount of covering were maintained so as to avoid overheating or chilling the patient. Privacy was maintained during the treatments. Where a special effort was needed to place the patient at ease emotionally, the nurse was successful.

B. Performance

In most instances, the patient was made as comfortable as the demands of the treatments would permit. A few minor points of comfort were overlooked. Where a special effort was needed to place a patient at ease emotionally, the nurse made a sincere effort to do so, but in certain situations she did not have the skill necessary to achieve success.

(*C* and *D* levels of performance are omitted.)

Four defined grades of performance for each of the factors involved in the performance of a public health nurse's work were given in a similar fashion. When they were completed, the supervisors realized that many of the classifications were imperfect. Some descriptions were inadequate, and distinctions between levels of performance in some instances were obscure. However, it was decided to experiment for a year with these measurements of performance and then to revise them.

FORM FOR RECORDING PERFORMANCE

Since evaluation was to consist of matching actual performance with standard descriptions of performance, a form was needed for recording the performance of the nurse. A work sheet entitled "A Record of Performance of the Staff Nurse" was set up, following the job-analysis outline. On this sheet, which also served as a report, was recorded in general terms a description of the nurse's performance on a given day as observed during a field supervisory visit. The performance for a morning, afternoon, or day (not for the individual home visit) was recorded in this fashion with supporting examples or factual data. Describing performance in administrative activities, recording, and maintaining community relationships is naturally a matter of cumulative evidence. Space was also provided for other items such as personality traits, apparent physical vitality, and a summary of strengths, weaknesses, and recommendations to the nurse.

The instructions for the use of the record of performance form were simple: "Describe under each item or aspect of work what applies to that item alone. Describe what the nurse did or said, giving an example or two." Above all things, a supervisor was not to express an opinion as to how well or how poorly she thought the nurse performed. Rather, the nurse's performance was matched, item for item, against the standards which had been adopted.

The aim of this experiment was to test the practicability of an objective rating of nurse performance. Although in the field of human relationships exact objectivity is not possible, the method of evaluation described has objective elements in it. It is first of all a method of systematically collecting and recording facts of performance—the first step in analysis. Second, it furnishes a definition of standards of performance on four levels to which the nurse's actual performance may be compared so that each nurse may know approximately where she stands and in what she needs to work for improvement. We have completed the first experimental period in using the job analysis, the descriptive measurements of performance, and the record of performance. Revision is now in progress.

How are these materials used? First, they are used administratively as a guide to planning the assignment of nurses to positions which they are capable of filling according to their quality of performance; and second, as a tool of supervision. We conceive of supervision as a joint undertaking, or coöperative endeavor, between the nurse and the supervisor to the end that the nurse may develop fully her capacity to serve people. Thus these materials are very helpful in aiding the nurse and the supervisor to work together to achieve this purpose. The essential factor in this democratic process is that of helping the nurse to see her job as a whole so that she will not neglect any one part of it, and so that she will be able to analyze her own work with a view to improving it.

USES OF THESE MATERIALS

Preliminary to using any new device, its use must be explained or demonstrated. The supervisor always explains the method of evaluation to the nurse. After a field supervisory visit, the supervisor and nurse review the nurse's performance, assisted perhaps by notes made in the home by the supervisor. The description is then recorded. The nurse compares her actual performance with the standards of performance and then she and the supervisor analyze the reason for rating her performance A, B, C, or D, and talk over what is needed for improvement. In the beginning, the supervisor may take the lead in making this analysis, but as the nurse acquires skill in work and self-analysis the supervisor is less active and eventually the nurse may be able to analyze her own performance without guidance—a desirable outcome of supervision.

The decisions agreed upon by the nurse and the supervisor for improving the nurse's performance are recorded under a heading, "Recommendations to the Nurse." At the conclusion of an analysis of performance, the staff nurse may sign the record or she may, in writing, comment on the analysis in any way she pleases. Should such a procedure seem inadvisable, the supervisor indicates that all or parts of the performance were discussed with the nurse. Administratively such a procedure is very desirable. Psychologically, in certain instances, a signed statement committing the nurse, as it does, to a certain course of action, has seemed to have a stimulating effect upon her. This record of performance is produced the next time the supervisor and nurse meet to analyze the latter's performance. Thus the nurse is given tangible evidence for judging her progress, or at least for having the satisfaction of knowing that she is maintaining a very desirable performance. Of course, it is possible that the performance may show retrogression.

The foregoing description of a method of evaluating nurse performance is not by any means an exhaustive discussion of the possibilities for its use either by the nurse alone or by the nurse and supervisor together. An analysis of all aspects of work, or of only one or two, should be made according to the needs and toleration point of the individual nurse. As the nurse in the home visit is guided in what she does by the situation in the home as a whole, so the supervisor in her analysis and evaluation has to consider the nurse as a whole—her educational background, and the physical, mental, and emotional factors contributing not only to the performance of her work but also to her relationship with the supervisor. Needless to say, time is also a controlling element.

STUDY OF GROUP PERFORMANCE

In addition to its use in the evaluation of individual performance, this method of analyzing and grading is valuable in obtaining composite ratings or pictures of nurse performance in a group. Such composite ratings, because they reveal

common strengths and weaknesses, provide direction for group staff education.

STUDY OF QUALITY OF SERVICE

With this idea in mind, the materials were carefully reviewed and it was decided they could be used to study the quality of service being rendered policyholders. The educational director of the Nursing Bureau was assigned as the surveyor to make such a study. Several experts in the field of public health nursing research were consulted. These specialists gave us real encouragement to proceed. When finally completed the plan for the study covered these points:

1. The service rendered policyholders by the staff nurse, including the nursing, teaching, and recording aspects of her work. (Since her administrative activities and community relationships could not be observed in the space of a short period, these aspects of the nurse's work were omitted from the study.)

2. The administration setup and functioning of the center, and the staff educational program, including formal programs or group activities as well as the supervision of the individual nurse.

This report is concerned chiefly with the findings regarding service rendered to policyholders.

The job analysis was to serve as a guide to the observation and recording of performance. For the purpose of the study, it was decided to describe in detail each visit rather than to describe several visits in general terms with supporting factual data, as was done in recording performance for purposes of supervision. Four forms, carrying the items *nursing*, *teaching*, and *recording*, and the contributing aspects of each, were drawn up providing for a combined check, narrative, and verbatim recording of what each nurse said and did on each visit observed. Preliminary to making the study, the surveyor tested her technique of observing and the suitability of the forms for recording her observations.

A period of three months was allotted to the study. Six centers in widely separated communities were chosen, representing staffs ranging from 8 to 33 nurses. Each nurse was observed for a period equivalent to a full day's work. The surveyor's schedule ran somewhat as follows:

The first morning was spent with a nurse. That afternoon the record of the observation was completed. The second morning was devoted to other phases of the study such as office administration, staff educational program, and so forth. That afternoon was again spent in the field with the same nurse. The third morning other phases of the study were considered. In the afternoon a second nurse was observed, and so on. The selection of nurses for observation was made at random from among those who had at least a year's experience on the staff of the nursing center. Altogether 135 home visits made by 23 nurses were observed and recorded.

STEPS IN SECURING DATA

The actual steps in securing the data were as follows: (1) Before going out with a nurse, the surveyor in conference with her reviewed the records of patients to be visited and secured from the nurse a statement concerning the purpose of the visits. (2) After the observation of home visits, again in conference with the nurse, the surveyor obtained additional information about each case: what the nurse had accomplished or attempted to do in past visits, especially in teaching, and what she planned to do in the future. Facts thus obtained were added to the data secured during the home visit.

An important part of the technique of securing accurate data on performance in any situation is the behavior of the surveyor. In this study she was introduced to families as a nurse new to the community and every effort was made on her part to be unobtrusive. She avoided rattling papers while taking notes; moved only when it was necessary to see or to hear; placed herself behind

and to the side of the nurse when the latter was at work; remained outside of the group of two or more when the nurse was teaching; and above all, did not participate in the visit. In fact, she found that for the most part she could quite easily confine her participation to the introduction of herself and to the farewell formalities. She did this so well in one home where the nurse had two patients—a baby and a four-year-old—that the child said to her, "You don't do anything, do you, the other nurse does all the work!"

The description of nursing performance was completed immediately following the period of observation of each nurse. All completed descriptions of performance were then held until all the nurses selected in the six centers had been observed and the data secured in connection with the other phases of the study. To gain a composite picture of performance, a scale of numerical values had been assigned to each contributing aspect of work outlined in the job analysis. When the study was completed, the actual performance on each visit was rated by the surveyor, according to the graded standards of performance previously described. The numerical scale was applied, a rating assigned, and a composite picture of the strength and weakness of each group of nurses observed in each center was obtained.

COMPOSITE PICTURE OBTAINED

What did this composite picture from each center show? From the nursing aspect, all the centers were practically on A or B levels when it came to maintaining the comfort of the patient. In organization of equipment and skill in handling it, with one exception all centers were on the A or B levels. As to finish—well, they were almost perfect! When it came to the basic principles underlying treatments and nursing care, a wider range of levels of performance was found. The range was from a low C to a high B. In fairness to all nurses on a staff, the fact should be emphasized that when the work of only a few nurses on a staff is surveyed, one individual's performance can lower the composite rating of the group as a whole. This was the case in one of the centers studied.

Teaching showed a similar range. Throughout the six centers it was found that in recognition of problems, five ranged rather closely at about the C level and one was on the B+ level. In recognition of attitudes, all were above B and several on the A level. On the other hand, in the analysis of problems, in the command of subject matter, and in skill in applying the principles of teaching, all but one center—which reached a good B—were grouped at about a low C level. In recording—that is, in accuracy and completeness of data and in legibility—all but one center ranged from a low B to a high B; one center was on the C level.

Since the study was based on a limited number of nursing visits, the results are inconclusive when it comes to evaluating the service of the 700 Metropolitan nurses as a group, but a continuing study to cover a large number of nurses is anticipated. As the supervisors become skilled in observing and recording the facts of performance, the data accumulated in their reports may be analyzed.

GUIDE TO STAFF EDUCATION

As has been said, we believe that the method used in the study is a serviceable detector of group needs. Supposing the whole group of nurses included in this study represents a staff. It is obvious what the subjects of staff education would be. In nursing, each group with the exception of one was weak chiefly in basic principles. So basic principles would be the focus of attention in nursing education. Organization of equipment and skill in its use and also the comfort of the patient would at the

outset be given very little emphasis in a staff-education project for this staff, because these are relatively on a high level.

In teaching, a picture of weakness is found in every link of the chain. This was shown by the Survey of Public Health Nursing published in 1934.* Correcting the weakness presents a difficult problem of staff education. But we see clearly what is before us. Certainly the emphasis should not be put entirely on subject matter to the exclusion of helping the nurse recognize and analyze problems and apply principles of teaching. What is the use of building up subject matter if a nurse does not see when to use it, or if she sees a need, is not able to analyze the situation, and through skillful teaching, help the family to work out a solution to the problem? Questions of this kind are concerns of individual case conferences; on the other hand, much can be done in group meetings and through study.

In this study of quality of service, *each single visit* was described and matched against the standard measurements of performance; the numerical rating was then indicated. On the other hand, in supervision *all the visits* observed during a supervisory visit are described in general terms under each aspect of work with specific examples. The actual performance is then matched against the standard measurements, and the level of performance is indicated by letter—A, A—, B+, B, B— et cetera. A staff interested in uncovering mutual strengths and weaknesses could quite easily make a study of two or three records of performance of each nurse. The staff educational program then could be developed around the needs indicated by the aspects of work most frequently and universally rated at C or D levels.

In this study of the quality of service, an attempt was also made to study in detail all factors which influence the nurse's performance. The findings showed clearly a definite relationship between quantity and quality of service, between quality of supervision and quality of service, between group staff educational activity and quality of service, between office administration and quality of service, and between agency policies governing the program and quality of service. Although in this study a survey of community relationships was not undertaken, it is recognized that services rendered by other community agencies influence the effectiveness of the nurse. It is encouraging to know that some current studies being made today are getting closer to this problem.

The method followed in this study is one which permits the observation, recording, analysis, and evaluation of performance in exactly the same manner as is used by the nurse and the supervisor in everyday supervision. We believe that a survey so conducted is constructive because the staff, through previous experience with the method, welcomes a study and is eager to accept the challenge of the findings.

For those interested in studying the performance of fairly small groups, the following observations may be helpful.

When a survey covers a small group, it would seem that the observation of nurse performance should be made on a selective basis. Probably the selection should be from those considered high and average in performance, including those in their first and second year of public health nursing. If possible, those chosen should include a goodly number who have had the background of at least a semester—but preferably two semesters—of preparation in a university program of study in public health nursing. In addition, nurses who have had only the benefit of staff education in the center or agency should also be included

*National Organization for Public Health Nursing. Survey of Public Health Nursing. The Commonwealth Fund, New York, 1934.

among those studied. Then by comparing the two it ought to be possible to gain some idea of the effectiveness of the program of staff education.

The number and types of cases to be observed in the field with the nurse should be determined on the basis of the time available for observing both nursing and teaching. For study purposes one half-day in the field with a nurse should be sufficient to gain a knowledge of her performance. This usually will make possible a review of the performance of a fairly large proportion of a staff.

If the aim of the study were to secure a picture of the teaching performance of which a nurse is capable, a study should not be made during the peak of the nursing case load—that is, when the average number of nursing visits per day is more than seven or eight. It is the observation of the surveyor that as the number of visits per day increases above that number, teaching performance goes down—and in most instances so does nursing performance.

A study of staff performance should be accompanied by an analysis of factors influencing the performance of the nurse, such as organization setup, administrative policies and practices (including office management), supervisory performance, educational activities both of staff nurses and of supervisors, and the policies and practices of other agencies contributing to the family health service and to the instruction of a family being served by the nurse.

Furthermore, a fair comparison of staff performance between nurses means that situations should be chosen which are as nearly alike as possible in simplicity or difficulty. That is, similar problems and home situations should be selected for observing nurse performance. The nurse confronted with taking a temperature, for example, should not be compared with the nurse confronted with a bladder irrigation.

What are the outcomes of the year's experimental use of the job analysis, the standard measurements of performance, and the record of performance as used in studying the quality of service of nurses of the Metropolitan Life Insurance Company nursing staff?

1. It is believed that we have a valuable guide in analyzing and evaluating the total job of a nurse. The first revision of the materials is already in process, but perfecting them and developing skill in their use will be a continuing staff educational project.

2. These materials—especially as used in the study of quality of service—show that a nurse's performance is affected by many factors outside her control, and in any appraisal of performance these factors should be recognized.

3. We have at hand a practical method of uncovering common needs of staff nurses, upon which to build programs of staff education.

4. We have gained a better understanding of what democratic supervision is and what it demands of the supervisor as well as of the one supervised.

5. We have already made a similar job analysis of a supervisor's work and are using a record of performance of a supervisor to analyze her strengths and weaknesses. The supervisors want standard measurements of performance against which to match their own performance!

6. A tangible evidence of response to this type of self-analysis is the fact that individual requests from nurses and supervisors for professional books from the library have increased by leaps and bounds during 1938 and the first half of 1939.

7. This method of study has helped the supervisors to discover what they need to do to perfect their part in supervision. It has also given them a new incentive to grow and to improve in the democratic processes of supervision to the end that they may inspire and help

nurses to develop their individual maximum abilities to render service to patients and their families.

8. Already these materials have proved indispensable for the entire administration of the whole service. The placing, the transfer, and the promotion of nurses to positions of responsibility are facilitated, and are more appropriately made, because it is known more accurately than ever before what a nurse has to give to a center and whether experience in a certain center will contribute to the growth and development of the nurse. A study of a nurse's record of performance assists in the selection of a nurse for a scholarship award and for helping her in her study program, including college work.

9. Finally, we have a means for making future studies and a guide to program planning.

The job analysis, the record of performance, and especially the standard measurements of performance are still in a formative state. Their use remains experimental in that we know that with continued use they will be perfected. They may not fit all types of organizations, but this account of them may be suggestive to some who are seeking a way to evaluate the public health nursing service rendered to the public. One thing of which we are certain is that we all need to go forward, and the surest way to go is through a careful analysis of the job and an objective appraisal of the work and the results obtained.

NATIONAL SAFETY CONGRESS

ATLANTIC CITY greeted the National Safety Congress with one of its balmiest autumn days, as industrial nurses gathered at the Chelsea Hotel facing the famous boardwalk, to discuss their problems in the annual meeting of the industrial nursing section, October 18 and 19.

The history and present trends in efforts to improve the health of the worker were reviewed at the Thursday luncheon by Dr. Donald M. Shafer, associate consultant to the Committee on Healthful Working Conditions of the National Association of Manufacturers. Dr. Shafer's address is published on page 677.

The importance—from the standpoint of efficient administration—of having the nurse directly responsible to the plant executive was stressed by Mr. J. M. Conway, president of the Hoberg Paper Mills in Green Bay, Wisconsin. Mr. Conway discussed the administration of the nurse's service from the executive point of view and outlined the personal qualities which the worker is most apt to value in the nurse.

Other problems of health in industry were discussed in papers and from the floor. Records and reports were the subject of a paper by Mrs. Isabel Poole of the Bigelow-Sanford Carpet Company, New York City. This paper, which was previously read at the meeting of the New England, New Jersey, New York, and Philadelphia Industrial Nurses' Associations in Boston on October 7, will be published in *The Trained Nurse and Hospital Review* for January 1940. "Living with Your Job" was discussed by Dr. Lydia G. Giberson, industrial psychiatrist of the Metropolitan Life Insurance Company in New York City. And the methods of health education used by nurses in their day-by-day contacts with workers were described, with interesting illustrations, by Dorothy Gray of the Kimble Glass Company in Vineland, New Jersey.

Improving the Health of the Worker

By DONALD M. SHAFER, M.D.

The Committee on Healthful Working Conditions of the National Association of Manufacturers is interpreting to employers the economic value of a health program

IN ORDER to discuss the health of the industrial worker it is helpful to review the past briefly to see what improvement has so far taken place. If we skip over the third century observations of Galen and the fifteenth century work of the German physician, Ellenbog—who wrote briefly about illness among goldsmiths—we come to Ramazzini. This early physician has been quoted and requoted for his excellent treatise on industrial disease which he released in 1710 with these words: "I choose to publish this treatise of mine for the good of the Republic, or at least for the benefit of Tradesmen."* Possibly even at that time there was some debate about government ownership versus private enterprise.

Ramazzini, who at that time held the chair of medicine in the University of Padua, was especially interested in the relationship between physics, meteorology, and medicine, and probably found industrial workers to be excellent examples of the conflict between nature's physical laws and human health. He understood the association between stone-cutting, mining, and lung disease, as well as between cleanliness and dermatitis.

However, from the time of Ramazzini till the twentieth century, there was little progress in industrial health, except for the minor benefits derived in England from the Factory Acts passed during the late eighteen hundreds. By this time, the United States was conscious of the industrial health problem, and even as early as 1726, we find laws of the Massachusetts Bay Colony containing the first industrial hygiene regulation passed in this country. "This Act was 'for preventing Abuses in the Distilling of Rhum, and other Strong Liquors with Leaden Heads or Pipes.' It is most interesting that Benjamin Franklin should make reference to this Act in a letter to his friend, Dr. Benjamin Vaughan, dated Philadelphia, July 31, 1786:

> "'. . . The first thing I remember of this kind was a general Discourse in Boston when I was a Boy, of a Complaint from North Carolina against New England Rum, that it poison'd their People giving them the Dry-Bellyach, with a Loss of the Use of their Limbs. The Distilleries being examin'd on the Occasion, it was found that several of them used leaden Still-Heads and Worms, and the Physicians were of Opinion that the Mischief was occasioned by that Use of Lead. The Legislature of the Massachusetts thereupon passed an Act prohibiting under severe Penalties the Use of such Still-Heads and Worms thereafter . . .' "**

The industrial accident toll, however, was a more dramatic and appealing subject than health, and it engaged the public's interest and recognition about 1913, when the National Safety Council was organized.

The progress of the safety movement has extended into many fields. In the industrial field there has been a reduc-

*Ramazzini, Bernardino. De Morbis Artificum. Padua. 1710.

**Seventy Noteworthy Medical Rarities in Honor of the Seventieth Birthday of Dr. Harvey Cushing, Schuman's Catalogue Five, New York, 1939, p. 31.

tion in fatalities of well over forty percent since the inauguration of the movement in 1913.[1] However, there is evidence to show that the accident rate of industry was becoming fixed, and since 1928, the number of deaths in industry has been practically parallel to the number of men employed and has changed only as the number of men in industry changed.[2] Additional evidence indicates that there was a reduction of only about 5 percent of the severity rate, and practically no change at all in the frequency of accidents, from 1932 to 1937.[3] This would indicate that under the 1932-to-1937 methods of prevention, industrial safety was reaching its saturation point. Without some basic change in approach, the 1937 loss of approximately 19,500 industrial workers[4] was well on the way to becoming an annual toll. However, in 1938 the frequency of industrial accidents again declined,[5] and the improved record may in no small part be due to a broader safety approach—one that includes health.

Probably the most promising way of continuing the downward trend in industrial accident rates in the future is to concentrate more effort on the health of the workman. This approach is perfectly logical, for it is obvious to all that a sick workman is more likely to have—or to cause—an accident than is a healthy man. This has been proved by careful analyses showing that 98 percent of all industrial accidents are preventable, and that only 10 percent of the injuries are due to mechanical hazards, while 90 percent are caused by man failure, either supervisory or otherwise.[6]

The great improvement that can be realized by additional attention to the health of the men has been demonstrated repeatedly under actual operating conditions.

Along with further accident reduction, a second great need in industry is apparent today. It is an improved employer-employee relationship. Probably at no time in the industrial history of America has there been so much discussion and controversy between the worker and the employer. We all are cognizant of the disturbances that have arisen over the entire country, and likewise, we all have felt that honest assistance and understanding of the other's problem would produce practical coöperation so that both can prosper and there can be a successful, working employee-employer relationship.

WORKER'S INTEREST IN HEALTH

That health is one of the most insistent problems of a laboring man cannot be doubted. Without it, his income drops or stops altogether, and he and his family lose their home and gradually their independence itself. It is therefore vital to him to keep his health.

The interest of labor has been demonstrated in several ways. One is the establishment of labor-union health centers, some of them handling thousands of cases each year. Recently an automobile workers' union established a medical center to determine the physical condition of its men and the presence of occupational disability.

Another way that labor signifies its interest in health is through the complaints of employee representatives to the employing companies. As an example of this, one company found that of several thousand cases cleared with the men's representatives, 73 percent were with reference to the plant working conditions.[7] Another company found that during a seven-months' period, only 24 percent of the grievances were due to wages and 8 percent due to hours, whereas 68 percent were due to working conditions.[8] This was in spite of the fact that both of these companies pay at least average attention to the working environment of their men.

It is apparent that labor is greatly interested in health, so it seems fitting that this subject should be firmly

stressed in any company's labor-relations program. An effective operating plan to improve the health and working conditions can cause a decided strengthening of the employee-employer relationship, and will work to the advantage of both.

Both topics that have so far been mentioned, namely, accident prevention and labor relations, are not primary results of improved employee health; they are in reality by-products. The man's health itself is both the means and the end. It makes possible the lower accident rate, the better labor relations, the improved production of goods, and, just as important, the improved consumption of those goods. Why then does not every company have a health program in operation?

The answer requires consideration of two fundamental points, lack of understanding and economics, as applied to three groups: the employees, the private practitioners, and the employers. In none of these groups is there complete opposition. There is rather a feeling of hesitancy, or inertia, or suspicion—always based on misunderstanding or ignorance of the potential benefits that each group can derive from factory health programs.

Within the first group, that of the employees, there is considerable interest in health, as has been mentioned. But it is sometimes colored by a hesitancy or suspicion in regard to participating in a factory health plan for fear of economic loss. Some men feel that preëmployment physical examinations will prevent men from getting a job and that check-up examinations will cause older workers to lose their jobs. They do not know that the best type of health plan rarely excludes even 5 percent of the applicants[9] and that even without examinations the physical condition of this 5 percent would soon cause them to be out of work because of illness, accident, or inability to do the job. Also, they do not realize that the examination is in reality an inventory of their ability to work so as to place them on the job that best suits their capabilities, and that it can frequently show them a way to improve their conditions and consequently their ability to work and earn. Practically the same situation is true with the older worker, who through the physical examination and health correction can make his years of earning power last longer.

It is only through education that these points of view can be altered. In addition there is, on occasion, the feeling that since the doctor is paid by the company he must be against the man. This attitude, likewise, must be met by education which honestly demonstrates that a healthy worker is the most valuable to the company and that the doctor's job is to help him be healthy.

It must be added that any health program that *does* discriminate against the men, or that is using the physical examinations to weed out men, is poor labor policy and is in its short-sighted way defeating the best interest of the company.

EDUCATE THE PRIVATE PHYSICIAN

The second group who play a part in the development of factory health programs, the private practitioners, frequently maintain an attitude of hesitancy or suspicion because of the fear of economic loss. To this is occasionally added a lack of understanding of the ethical arrangement between a company doctor and themselves. Because of this misunderstanding, a factory health program of real merit is sometimes handicapped. The situation can ultimately be solved by education through such an agency as the Council on Industrial Health of the American Medical Association.

One large part of this education consists of enlightening physicians in regard to industrial health work itself—both in order to interest more doctors in the field and to have them realize that having a

physician on call for emergencies is not a factory health program. Furthermore, they should be shown that a factory health program still may have emergencies and that the two are not *necessarily* incompatible. The true picture of the contribution that a factory health plan can make to the welfare of the community's private doctors must be presented before their inertia can be overcome.

PROBLEM OF SMALL EMPLOYERS

The third group that can promote the development of factory health is the employer. Within this group there are two classes of employers, as we all know: Those in the first class have not only developed excellent health programs in their own plants but they also actively support industrial health and hygiene research and education. Those in the second class have not made this advance in factory health and frequently have little conception of the part that a health program can play in a company's prosperity. This second class is, in general, made up of the smaller sized companies and is in great need of education on the entire subject, especially on the economic aspects. It is with them that the Committee on Healthful Working Conditions of the National Association of Manufacturers is dealing.

To answer the question of why there is not a health program in every company, we find that these three groups must be educated: labor, the private practitioners, and the employers. Labor seems most approachable through the general public at the present time possibly through government agencies. The private physician can be approached best through national, regional, and industrial medical societies. Employers can be reached by means of trade and manufacturers' associations. Until each group fully realizes the value of industrial health to itself and its future, the work will be incomplete.

N. A. M's. HEALTH PROGRAM

The work of the Committee on Healthful Working Conditions is directed toward the manufacturer. Through this Committee, the National Association of Manufacturers' 7500 members are trying to assist the manufacturers of the country—especially those in the small plants—to recognize the value of an employee health program and to put such a program to work in their plants.

The Committee's consensus is that the small plant, employing over 60 percent of the nation's industrial workers, is the crux of the present factory health problem. This fact has been supported by repeated analyses of the situation by the American College of Surgeons, state industrial hygiene departments, and others.

For the past year, the Committee, assisted by its advisory committee of industrial physicians, has been compiling all available information on the subject of small plants, and has endeavored to find just what the key log in the jam has been. After setting aside the hindrances that have been mentioned above, we have found two such key logs. The first has been obvious—cost. The second is not so readily defined. Primarily, it is the lack of education, but it is entangled in a feeling held by manufacturers, as laymen, that this is a doctor's problem and that they do not know anything about it. Furthermore, they are not sure that they, as individuals, should know anything about it. It is probably the converse of the feeling that because a man has a medical degree he cannot be a business man or anything but a doctor. The best answer to this seems to be a straight dollar-and-cents statement of factory health as a business proposition. This approach is, we believe, close to the manufacturer's interest and experience, and should receive more consideration from him.

The Committee has also prepared

pamphlets of instruction for the manufacturer, showing him exactly what he can do in his plant to set up a health program. A new pamphlet shows very briefly and to the point how a health program can bolster the safety work in the plant and how the company can be benefited in a practical manner by such a health plan.*

In addition to the production of such educational material, the Committee is seeing active service as a source of information on specific health problems in industrial plants. One day's mail contained an inquiry on how to prevent the so-called cyanide rash from a mill in the southern state of Alabama, and another question on the identical problem among mine workers 150 miles north of the end of the railroad in Canada.

The public has been interested in the activities of the Committee, and this has resulted in the publication of numerous articles in magazines and in the press. One feature article, containing the aims and work of the Committee, was syndicated and went to a guaranteed circulation of six million readers. We believe that the maintenance of each of these activities—the education of manufacturers, a clearing house of factory health problems, and public information—cannot help but assist the work of improving the health of industrial workers.

In summary, a concentrated effort to improve the health of industrial workers appears to be the most promising way of further reducing industrial accidents in the future, and in addition, can be a major contribution to labor relations at a time when a good employee-employer relationship is of prime importance. This improvement, however, is slowed down by the inertia of many employees, private physicians, and smaller employers, and can only be accelerated by thorough education of each group. Education of the employer group is the goal of the Committee on Healthful Working Conditions. It is actively encouraging employers to further improve the health of their men, and is providing direct educational material, advice on factory health problems, and public information toward that end.

* This pamphlet will be available soon from the Committee on Healthful Working Conditions, National Association of Manufacturers, 14 West 49 Street, New York, N. Y.

Presented before the Industrial Nursing Section, National Safety Congress, Atlantic City, New Jersey, October 19, 1939.

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The Clinic Interview

By MARY J. DUNN, R.N.

The potentialities of the clinic interview as a major factor in syphilis control are discussed by a regional public health nursing consultant of the U. S. Public Health Service

A NEW EMPHASIS has been given to a very old problem during the past two or three years. As a result we find programs for the control of syphilis launched in all quarters. Manuals of standards of performance and of procedures have been evolved. Reams have been written on the interpretative interview. Such terms as "case-finding," "case-holding," and "contact-tracing" have become a part of the vernacular of many professional groups, including physicians, social workers, and public health nurses.

Despite this encouraging keynote, there are still far too many evidences of a disregard of widely known and generally accepted good practices, including the most productive use of the clinic interview. The reasons for failure are already known to the professional worker. Suffice it to say that until greater effort is made to provide a better ratio of professional personnel to patients, to plan for a time most convenient to the clientele, to appraise physically the patients to be treated, and to provide for a satisfactory interview for each patient, progress will continue to be impeded. Accomplishment cannot be realized out of chaos but rather out of a well ordered, well conducted clinic.

A qualitative service rather than a quantitative one should be the goal in the control of syphilis, as in the control of any communicable disease, or in the promotion of any health program. Not *how much* but *how well* should be the criterion.

Mention has already been made of the importance of the clinic interview as a qualitative factor in syphilis control. In discussing the interview, several questions merit consideration:

First of all, what are the objectives of the clinic interview? What do we hope to accomplish by it? Our aims may be summarized as follows:

To create an attitude and understanding on the part of the patient that will result in voluntary and continued treatment.

To help the patient develop an understanding as to how syphilis is spread and to stimulate in him a desire to prevent others from becoming infected.

To encourage the patient to feel a responsibility for medical supervision of all persons with whom he has been in intimate contact.

Who is the logical person—or persons—to instruct the patient in the syphilis clinic regarding the nature and treatment of the disease and precautionary measures, and to ascertain from him the possible sources of infection and contacts?

Psychologically and logically it would appear the responsibility of the physician. It is he who informs the patient regarding his diagnosis. It is the physician who makes a complete physical examination of the patient prior to prescribing a course of antisyphilitic treatment. It is inconceivable that these services could be rendered either to the satisfaction of the physician or of the patient, unless accompanied by certain fundamental instruction, based on clinical findings as well as on pertinent information gleaned from the patient. A few additional minutes given by the

clinician, to new patients particularly, will be repaid by better understanding and coöperation.

SUPPLEMENT DOCTOR'S INSTRUCTION

It may be assumed that much of the general information called for on case records, such as the name, address, marital status, age, color, and sex, may be secured by a clerk or some other designated assistant. However, the securing of the more personal data pertaining to possible exposure to the disease, time of exposure, and known contacts—all of which relate so closely to the diagnosis, stage of infection, and treatment involved—would appear a vital and contiguous part of the medical service. Such a procedure is recommended by many public health experts.

Following the initial interview of the patient with the physician, the public health nurse (or medical social worker) should supplement or clarify the information given the patient. The necessity for repeating or supplementing this instruction is apparent because of the following reasons:

1. The pressure of time in the busy clinic may make it necessary to limit somewhat the time that the physician may devote to each patient.

2. While it is desirable on the occasion of the first clinic visit to give the patient all he can grasp in way of instruction, it is equally important to allow him the opportunity to express himself—to learn what he is thinking.

3. Frequently a diagnosis of syphilis is emotionally upsetting to the patient, resulting in his inability to focus on the physician's instruction or information beyond the report of the diagnosis.

4. A reticence on the part of the patient to disclose pertinent information to the physician on first questioning may be followed by a willingness to impart such information later to another interviewer.

The statement is made repeatedly that syphilis is to be considered in the same way as any other serious communicable disease. Scientifically this statement is true. But because of its many social and personal implications—all of which must be recognized by the professional worker—syphilis falls in a unique category. Its roots are imbedded deeply in something very fundamental—intimate sexual life. It is likely to disturb and disrupt marital harmony. It tends toward further emotional instability, manifested by a feeling of chagrin, a loss of self-esteem and fear of losing the esteem of others. It results in a loss of personal freedom because once a diagnosis is established there is little or no choice as to treatment. It may precipitate the element of fear—fear of treatment and all it involves; fear of losing one's job if the diagnosis is known to the employer; fear of publicity because of the legal or compulsory implications relative to reporting and treatment. All of these factors must be taken into consideration by those who interview the patient to discuss with him the nature of syphilis and its treatment, and the possible sources of infection and contacts.

Can there be a clear-cut line of demarcation indicating where the instruction of the physician ends and that of the public health nurse begins? It is believed no positive statement can be made on this point, except that the physician—and *always* the physician—informs the patient of his diagnosis, and that the giving of this information should be accompanied by at least a minimum amount of instruction by the physician. Surely we need not quibble over who is responsible for what. The important question is whether we as professional workers are eager to mobilize our forces to make a unique contribution in the attainment of a common objective—better case-holding and case-finding through the well instructed and coöperative patient?

In order to attain this goal the following assumptions must be made:

Those participating in the syphilis-control program need to be well versed in their respective fields. Such versatility should include a fine interest, understanding, and acceptance of patients, a full knowledge of the nature of the infection and treatment for it, and dexterity in the administration of treatment.

The health agency concerned should adopt definite policies of procedure which are known to every worker and observed by all. These include policies governing (1) the relationship with the private practitioner (2) the selection of patients to be treated (3) the examination of contacts (4) the selection of patients to be visited (5) other methods of case-control. The foregoing merely suggest—and by no means exhaust—the type of information necessary for an effective syphilis-control program.

The first interview with the patient after the confirmation of the diagnosis should be used to establish an intelligent understanding and coöperative relationship between the patient and the treatment agency. Some workers delight in lauding the value of "shoe-leather" epidemiology. But why resort to the waste of time and of shoe leather if an equally good or superior service may be performed at the clinic?

TEACHING VERSUS LEARNING

Thus far, our attention has been focused upon such general aspects of the interview as the aims, the difficulties encountered, the participants, and the importance of the first interview. This discussion would be incomplete without referring to the actual content and sequence of the interview. A safe working principle may be to assume the patient has little or no knowledge of syphilis. Furthermore, we cannot say we have taught until the patient has learned. The patient will not be receptive to learning until he has confidence in the worker, confidence in himself, and a feeling of responsibility for his treatment.

Quite normally, a patient's first concern is himself. Therefore, one of the first responsibilities of the interviewer is to help the patient view his problem objectively and plan for carrying through the prescribed treatment. In order to understand his problem and make plans, the patient needs to be informed regarding the long period of time a series of treatment requires, what may be hoped for as a result of continuous treatment, the dangers of interrupting treatment, and the fact that occasionally there are contraindications to treatment which should be noted and reported.

If the instruction has had meaning for the patient and he has a realization of the seriousness of the infection and the necessity for treatment for himself, the interviewer may next introduce certain instruction regarding the protection of others. He will endeavor to gain the patient's coöperation in securing medical supervision for those who may have been exposed to the infection. Our primary concern is not in discovering the individual from whom the disease may have been contracted but in getting all contacts under medical supervision. In contact-tracing it should be borne in mind that the important consideration is sex contacts rather than household members.

After securing the patient's interest in getting contacts under care, the worker may talk over with him whether he will be responsible for inviting the contacts to be examined or whether he wishes the worker to assume this responsibility. It may be mentioned to the patient that if there is certain apprehension or opposition on the part of the contacts, they may be examined elsewhere than at the clinic.

This discussion has outlined briefly

the major points to be emphasized in a clinic interview. What may be accomplished in the way of case-holding and case-finding depends upon:

1. The clarity, definiteness, concreteness, and practicability of the advice offered to the patient.

2. The opportunity given the patient to make certain decisions and plans.

3. The extent to which the interview is the patient's rather than the worker's. "There is a time for speech and a time for silence; and one must be silent in season."*

*White, Wendell. The Psychology of Making Life Interesting. The Macmillan Company, New York, 1939, p. 11.

News from the S.O.P.H.N.'s

RHODE ISLAND, 48 miles at the longest point and 37 miles at the widest, certainly presents no physical difficulty when we want to get together. Indeed, one might wonder how 690,000 people could fit comfortably into 1053 square miles without treading on each other's toes. Our size certainly makes it imperative that we thoroughly understand each other in order to avoid confusion. The following report of some recent activities of the State Organization for Public Health Nursing shows that we have retained our identity as an organization while working in harmony with other groups throughout the state.

Early in 1939 the executive boards of the State Organization for Public Health Nursing and the Rhode Island League of Nursing Education gave consideration to the advantages of combining the efforts of the two organizations in planning for college courses for graduate nurses. A joint committee was appointed from members of the Education Committee of each organization. This joint committee made a survey of the facilities available to Rhode Island nurses who wish to take college courses. Representatives of local colleges—Providence College and Brown University—were interviewed. Conferences were held with representatives of the Massachusetts League of Nursing Education and with Simmons College and Boston University in regard to nursing education courses offered. Seven conferences were held from March 10, 1939, to August 3, 1939. A letter of information containing the results of the study by the joint committee was mailed to every member of the S.O.P.H.N. and the League.

The two outstanding advantages of this coöperation in planning for college courses are:

1. The graduate nurse group as a whole will be given consideration in future plans for college courses.

2. The total number in the combined groups will no doubt influence colleges and universities in setting up programs which will more adequately meet the needs of the graduate nurses of Rhode Island.

Regional meetings were extended throughout the state in 1938 as a project of the education committee. The idea grew out of a request from a board member for more educational activities for her group. Their expressed need at the moment was to clarify the relationship between public and private agencies. The expansion of the State Health Department, due to the provisions of the Social Security Act created confusion in the minds of the laity as to just what were the functions of each agency. The basis of this confusion seemed to be a fear that the private agency was doomed

and this was particularly true in the rural areas.

The first regional meetings centered their discussion around this problem. Meetings were held in the three new health centers established by the State Health Department. The medical director of each unit was asked to tell about his program, and one outside speaker discussed the problem from the point of view of the private agency. The meetings were successful from the point of view of attendance and results. Discussion was more active than at larger state meetings. We had an opportunity to know each other. Nurses, physicians, board members, and public health officials met, often for the first time.

This year regional meetings are being continued, and on a better, more permanent basis. In 1938 the education committee took full responsibility for them. Now there are subcommittees for each area. The chairmen are active board members who are also members, *ex officio,* of the Education Committee. The first regional meeting under the new plan proved that the enthusiasm expressed a year ago was sincere. At an all-day meeting and luncheon the attendance exceeded many a state meeting.

The state Committee on Nursing Education has been making a study of standing orders for public health nurses throughout the state. Its preliminary report of suggested standing orders has been referred to the State Organization for Public Health Nursing for discussion. At present the S.O.P.H.N. has an active committee working on this report and in a few months will have recommendations ready for the Committee on Nursing Education. These standing orders will include school and industrial nursing.

The coördination of nursing activities in the smallest state is emphasized by Nina D. Gage, president of the State League of Nursing Education, who says:

In Rhode Island the three nursing organizations coöperate as if they were different departments of one organization, all working together for nursing in a unity which too often does not get expressed in other states. We have followed the plan of the national associations, and our respective presidents are *ex officio* members of the boards and of some committees of the other two associations. The League has many public health nurses among its members and officers. This official coöperation gives us all a much better correlation of nursing work, and makes possible a very delightful relationship. We would recommend it to larger states for fuller functioning of nursing work.

MARY C. MULVANY, R.N.

President, Rhode Island State Organization for Public Health Nursing

Shall We Have Men on the Board?

QUESTIONS have often arisen in board discussions as to the advantages and disadvantages of mixed boards of public health nursing associations. Organizations frequently write the National Organization for Public Health Nursing asking whether they should have men members on their board. As a result of these questions it was thought wise to get a picture of the thinking of existing boards on this subject. Last winter a letter was sent by the N.O.P.H.N. to twelve boards of visiting nurse associations, part of which have a membership comprised of men and women, and part of which have only women members. No final conclusions can be reached from the letters that came in. The agencies having mixed boards thought that they would not want a board made up only of women, whereas those with all-women boards were equally convinced that their set-up was the most valuable.

However, the viewpoints advanced brought out some very interesting points which may serve as a guide to board members who are studying this question. One organization having a mixed board, for example, interviewed each individual member separately for his or her point of view. One executive director sent in arguments both for and against men on the board, although she is an executive of an organization having a mixed board.

Some of the statements in favor of all-women boards of public health nursing organizations are as follows:

A board of directors composed of women is a more efficient working board, as we are directing the work of women. We have twenty-nine women members on our board and one man. The latter is the manager of health and charity for the city and county. We feel he should have a vote on our board because we do all the public health nursing for his department, for which we are paid by the city. His duties do not permit him time to attend our meetings, but we confer with him when necessary.

A trust company which manages our endowments acts as consultant in regard to our investments. We have a legal advisor and a medical advisory board, and with this assistance we believe our work is carried on as efficiently as if men served on our board.

In addition to being responsible for the work of the Young Men's Christian Association, Boy Scouts, and other similar organizations, men are now called upon to be on the boards of many more agencies than formerly—such as community chests, councils of social agencies, and civic committees; and we believe they could be relieved of this service to visiting nurse associations, which it has been proved can be conducted in an outstanding manner by women.

We have monthly board meetings, held at ten o'clock in the morning and lasting approximately an hour and a half, which have a high average attendance and which hold the interest of the women from the beginning to the end. Adding men to the board would necessitate a change in the hour of the meeting, thereby perhaps reducing the attendance of the women, and no doubt the meetings would be shortened. In this curtailment some of the appeal of the work which makes it so vital and worth while to women might be lost.

Practically all the men in our community commute, which would mean holding evening meetings instead of meetings in the morning. It is far more convenient both for the director and our board, who are mostly mothers, to hold morning meetings. Also it is easier to get representatives from our state health department, who occasionally attend board meetings to acquaint us with our state program in health. Therefore the hour plays an important part in our preference for a women's board.

In the matter of committees, the main work of our agency applies to women—with the exception of the financial committee which might very valuably use men when the problem of investment comes up; but as we do not have large amounts to invest it would be possible to call upon them to aid us in such matters. Men, I am sure, would not take the time to do a cost-per-visit study, or plan the details of an annual house-to-house canvass. We have, of course, a medical advisory committee which helps our board members and nurses solve perplexing problems.

The consensus was that we started as women, and we find that it works! As we have meet-

ings every week in the morning, it would be impossible to have men give as much time as that. We have also the men's advisory committee, three of which form the men's advisory finance committee, and we have them back of us ready to help if any question comes up that we feel important enough to call on them for counsel. When we do ask them to meet with us, seldom as it is, we have great difficulty getting them together as they are all very busy. But the three financial advisors do go over investments, and several of them come to our annual meeting.

Following are several statements in favor of having men on boards:

We have found over a period of years that the men are invaluable in keeping discussions on the subject to be discussed. The whole level of our thinking and procedure is higher because they bring a less emotional, more businesslike point of view to the solution of problems. They are more impersonal than women, as a rule.

It is quite impressive in a community to have men who are highly respected and known to be busy, representing public health nursing, defending it in meetings, answering questions concerning it intelligently . . . Certainly men reach a different group to educate in regard to public health nursing than women; and, from that point of view, if intelligent women conversant with public health nursing are an asset to the organization, intelligent men equally conversant are equally valuable.

Our board is very enthusiastic over the new set-up with men as members . . . We have two bankers, an editor, the head of the city health bureau, an expert accountant, a pediatrician, and a prominent member of the community chest board. Their attendance has been remarkable and we feel that they have done a great deal in keeping the women on their toes, as one member expressed it. They have definite jobs and are not asked to serve on such committees as membership or nursing.

I think having men on the board is one of the best steps we have taken and the fear they would not attend meetings or take an interest was absolutely unfounded.

Most men like being on the board. They enjoy the financial problems; they are always interested in demonstrations; and they seem to feel that public health nursing has a clear-cut program and is well organized. Several of our men have come back after being off for a year or two. They have worked on by-laws, helped prepare the budget, worked on public relations problems, attended meetings planned purely for the purpose of orienting new board members, and done every kind of job on our board.

Our board feels that it is essential to have men on it, because:

1. When both male and female viewpoints are brought to bear upon a question, the decisions reached are apt to be well balanced.

2. Men can bring to the board the business man's viewpoint.

3. Men are better trained to deal with financial questions. (Our treasurer and chairman of the finance committee is a man, and the majority of the members on his committee are men.)

In publicizing the work of the association the mixed board is an advantage for it enlarges the circle of contacts and makes it possible to make more diverse the character of "missionary work" among the uninformed and prejudiced.

Mixed boards are valuable, because:

Providing the representation is reasonably well balanced, the nursing association has the benefit of the knowledge and judgment of women familiar with home life and its health needs and who are naturally interested in the association's activities, and men of professional or business experience who are active in community life and whose connections and spheres of influence are of great value in the financial support of the association. Such a mixed board builds up a broader contact and influence for the association, in the life of the community.

The presence of men on the V.N.A. board takes it out of the class of fads—those groups which keep women occupied, often to no avail. A mixed board seldom wastes time on non-essential arguments and a treasurer who is a banker seems ideal.

The mingling of interests through a board composed of both men and women seems to me particularly desirable in an organization such as the visiting nurse association.

Also, they are said to be active in bringing before the city fathers the need for a full-time health officer, and often are able to obtain assistance from public funds in furthering the program of public health nursing.

It is realized that these comments represent only a few of the many boards of directors of public health nursing associations throughout the United States, but they do bring out different points of view which we hope may be of use to local organizations. E. K. D.

Providing Continuity of Maternal Care

By CLYDE ALLISON BOICE, M.D.

A private physician discusses a rural maternal health program which has been made possible through the interest and support of the medical group

THE PROBLEM of providing an adequate maternal hygiene program in rural areas varies according to the economic status of the population and the medical, nursing, and hospital service available. A maternal demonstration program based upon the needs of the area is now being carried on in Washington County, Iowa, by the members of the county medical society in coöperation with the county health unit and the county hospital.

Washington County in southeastern Iowa is a typical rural county having a population of approximately 20,000 and an area of 562 square miles. The county seat, Washington, is a city of 4800, centrally located. There are seven towns in the county with an average population of less than 1000. The county seat has a population of about 3500. Each has one doctor.

Half of the population lives on farms. There are a few industries in the county but it is essentially a farming community. Practically all of the inhabitants are native-born and there are less than fifty Negroes in the county. Economic conditions are essentially good. Approximately half of the farms are operated by tenants. About 4 percent of the people are on relief, which is less than one-half the figure three or four years ago. Only about 4 percent of the farmers are receiving government rehabilitation loans. For the last two years, relief has been provided by local funds.

The Washington County Medical Society has always taken an active interest in public affairs, and in 1924, it fostered the establishment of a county health unit—the first in the state. By 1936, the unit had become firmly established with well trained personnel in charge. At this time, arrangements were made to organize a maternal and child hygiene service as a part of the program of the health unit. The county was selected by the State Department of Health as a maternal health demonstration area for the state.

Certain factors were favorable to the establishment of this maternal program. Every medical practitioner in the county is a member of the county medical society, which has had a record of activity in health matters over a period of years. The society has for a number of years had a contract with the county board of supervisors for the care of the indigent, obligating the physicians to give a full medical service for a reasonable fee. The sick person has the right of choice of physician. The plan has been eminently satisfactory to all concerned. There is a 35-bed county hospital which serves all residents of the county regardless of financial status. It provides ample laboratory facilities for chemical and bacteriological examinations and x-ray pictures and gives service to physicians in the county. The laboratory is in charge of a graduate medical technician.

It has been realized from the beginning that without the active support of the

physicians and the receptive support of the public no public health measures could succeed. These objectives were not attained in a few weeks. A constant educational campaign for better health has been conducted in the county over a period of years, emphasizing (1) the development of a coöperative spirit on the part of the physicians (2) the securing of an appreciative support on the part of the public. This public includes the newspapers, the schools, and various organizations such as men's service clubs, the Chamber of Commerce, the parent-teacher association, the Farm Bureau, and the Federation of Women's Clubs. An effort has been made to reach every family in the county with the educational work.

There are in the county at the present time 19 active practicing physicians—about one to every 1050 population. Of these, fourteen are engaged in general practice, including obstetrics. The physicians taking part in the maternal health demonstration are therefore not specialists but general practitioners.

RECORDS AND EXAMINATIONS

From the first the necessity for adequate records on every case was recognized and stressed repeatedly to the physicians. Gradually these records have grown towards completeness as experience and education have shown the need, until at the present time they are quite complete.

At the first examination of the patient, the doctor is expected to obtain a satisfactory history, make blood-pressure readings, do a urinalysis, and obtain blood for a syphilis test. The importance of this requirement has been stressed to the physician and the patient until at the close of three years it is a recognized procedure. It is not now necessary for the doctor to argue with the patient regarding the necessity for these examinations. They are taken as a matter of course.

Blood examinations would indicate that syphilis among women is of very minor importance in Washington County, the positive tests being less than 1 percent of those made. Iowa has just enacted a law, effective July 4, 1939, requiring that the physician take a blood specimen from the pregnant woman at the first consultation, or within fourteen days, for examination as to presence of syphilis. If a positive report is received, the husband and children must also be examined. Washington County was at least three years ahead of this law. In the last one and one-half years, Kline tests have been routine on all patients in the county hospital. Patients with positive tests are referred to the state laboratory for rechecking. Persuading private physicians to make routine blood tests was difficult early in the maternal health program. However, during the last year about 90 percent of the records turned in have Wassermann slips attached.

SERVICES AVAILABLE TO PATIENTS

When the maternal demonstration was started a nursing service was provided by the county health unit to give antepartum and postpartum supervision and home-delivery nursing care to mothers. (See page 693 for a description of the nursing service.) At the same time, an arrangement was made with the county medical society whereby all of the medical practitioners in the county doing obstetrical work agreed to give medical care and supervision to all expectant mothers. This service was to be given in the offices of the participating physicians, regardless of the individual's ability to pay.

Hospital care was already available to indigent patients in the county hospital, and delivery service for such patients had been provided through the contract between the board of supervisors and the county medical society, referred to above. Therefore, with the

nursing service and provisions for antepartum care made available as a result of the maternity demonstration, it was possible to provide adequate medical, hospital, and nursing service to every expectant mother in the county regardless of her ability to pay.

Continuous maternal care today is generally recognized as including: (1) adequate antepartum care beginning early before the third month in pregnancy and medical and nursing supervision up to the time of delivery (2) good obstetrical and nursing care at the time of delivery (3) proper medical and nursing supervision of the mother and child following delivery.

In addition to arranging for medical, nursing, and hospital facilities, there are other objectives of the maternity program in Washington County such as:

1. To educate expectant mothers as to the importance of seeking early antepartum care.

2. To educate physicians to provide good antepartum care with particular emphasis on routine blood tests and the keeping of adequate records.

3. To get physicians to report every expectant mother to the nursing service for nursing supervision.

4. To provide for aseptic deliveries in the home by furnishing sterile obstetrical packs to the physicians for home deliveries.

5. To provide delivery nursing service in the home when it is desired by the physician, and the family income does not exceed $1250 a year.

6. To provide nursing supervision of the mother and infant immediately following the delivery. The nurses are at all times under the direction of the family physician. Particular emphasis is placed on supervision of premature or debilitated infants. A portable incubator is available for caring for premature babies in the home.

7. To stress the importance of postpartum examination of the mother and regular medical supervision of infant, the latter to include vaccination for smallpox and diphtheria immunization.

8. Last, but not least, the most important objective is to reduce the maternal mortality rate.

A program for maternal health must first determine the need. A knowledge of the number of births per year in a given county and some knowledge of the morbidity and mortality not only of mothers but of babies is essential. There should also be a knowledge of the capabilities of the medical practitioners of the county, and their willingness to coöperate with each other and with the organized agency.

VITAL STATISTICS

During the ten-year period from 1929 to 1938 there were 3328 live births in the county—an average of 332 a year. There were 84 stillbirths during the same period. The average infant mortality rate for the five years from 1930 to 1934 was 38.7 per 1000 live births. For the four years from 1935 to 1938, the infant mortality rate was 33.7 per 1000 live births.

The maternal mortality rate during the five years from 1930 to 1934 was 4.2 per 1000 live births. During the succeeding four years from 1935 to 1938, the rate was 3.5 per 1000. In the past two and one-half years there has been but one maternal death in 922 deliveries.

In the year 1934 there were 337 infants born in the county. Twenty-nine and four-tenths percent of the births were in the hospital, which is at least twice the figure for the United States. In 1937, 40.7 percent occurred in the hospital; in 1938, 51.9 percent were in the hospital. In 1937, in addition to those babies born in the hospital, the maternity nurses attended sixty-eight in the homes, and other graduate nurses attended fifty-three more. This means that 70 percent of the deliveries in the county were attended by graduate

nurses. In 1938, in addition to those babies born in the hospital, the maternity nurses were present at the birth of sixty-eight infants, and other graduate nurses at the birth of fifty-one—which means that 83 percent of the deliveries were attended by graduate nurses. For the first half of 1939, out of 181 births 93 percent were cared for by graduate nurses.

One of the emphasized objects of the health unit is adequate antepartum care. In 1930, only 45 percent of the pregnant women had antepartum care by the end of the eighth month. In 1937, 43.4 percent had antepartum care at the end of the third month, 71 percent by the end of the sixth month, and 81.8 percent by the end of the eighth month. In 1938, 45.2 percent had antepartum care at the end of the third month, 82.4 percent by the end of the sixth month, and 91.4 percent by the end of the eighth month. All births were attended by a physician.

As a private physician the writer believes that a maternal health program such as the one in Washington County has certain benefits: It offers an opportunity to improve the physicians' capabilities by refresher courses and the insistence on full records. The physician, having better training and increased interest and equipment, will be inclined to do better work or possibly more acceptable work for those whom this service is intended to reach. Making health services readily accessible will minimize illness, lessen deaths, and improve the social conditions of those reached by the services.

It is our firm conviction after many years' experience in public health work that no plan will be successful without certain conditions: First, there must be an active interest and coöperation on the part of the physicians of the community. This interest must include a receptive attitude towards changes in methods of delivery service, an appreciation of the rights of the public to receive high-grade medical care, and a wish to continually improve the type of medical service which is given. Second, there must be the education of the public in regard to the importance of good medical care and the standards of medical care available from the local physicians. This attitude of the public must include the knowledge that certain diseases are preventable, that childbearing all too frequently has pathological significance, and that physicians are able to minimize these dangers. Finally, there should also be the coöperative assistance of a good hospital which will include not only laboratory service for chemical and biological work, but also x-ray service when indicated, the measuring of the pelvic contour, and the determining of the position of the fetus. And of course this service should be under the direct control of a medical technician.

Presented before the Joint Nursing and Public Health Sections, The First American Congress on Obstetrics and Gynecology, Cleveland, Ohio, September 12, 1939.

A GUIDE TO THE SCHOOL NURSE

The provision of adequate and practical hand-washing facilities constitutes an important problem in school health. Page 698.

A Western agricultural college has developed a health program attuned to the personal needs of the students. Page 700.

The care of crippled children requires the coördinated efforts of all who are interested in the handicapped. New Jersey has taken the first step—a study of all the nursing facilities available in the state. Page 703.

The babies of today will be the school children of tomorrow, and school nurses are increasingly aware of their responsibilities for adequate maternal and infant care. Pages 661, 689, 693.

Home Delivery Service in an Iowa County

By ALMA E. HARTZ, R.N.

The home delivery nursing service described here is part of the maternal health program outlined by Dr. Boice in the previous article

THE MATERNITY service in Washington County, Iowa, is an integral part of the program of the county health unit.* When the service was started on June 1, 1936, a public health nurse was employed to make antepartum visits and to help families arrange for delivery and postpartum nursing service. This care was to be given by private duty nurses living in the area. As many as seven days of postpartum nursing service were available to indigent families or those which were medically indigent—that is, having a borderline economic status.

Washington County is a typically rural Iowa county having all the problems of transportation due to heat, cold, mud, and snow. Problems of travel for the nurse began to loom since only a few of the private duty nurses had automobiles. Sleeping facilities and food were often limited. Nurses objected to remaining in homes under such circumstances and after three months this plan was abandoned. A second public health nurse was employed and since that time the two maternity nurses have given nursing service at the time of labor and delivery and postpartum nursing care, in addition to antepartum nursing care. These nurses are provided with automobiles.

*The staff of the county health units now consists of a medical director, a public health engineer, three public health nurses, an office secretary, and a part-time lay person who is assigned to the supply and work room.

In the beginning of the service two routine antepartum visits were made to each mother registered with the service—one as soon as possible after the mother was registered and one during the last two months of pregnancy. Postpartum visits were made on the first, third, and seventh to tenth day, and again from five to eight weeks after delivery. This policy has been discontinued for several reasons. Some of the women have received instruction during previous pregnancies and are making good applications of the knowledge. Others require more than two visits; complications arise which make more than two visits imperative. Visits are now made on the basis of individual need.

All mothers may have antepartum nursing service and demonstrations of maternal care and care of the infant during the puerperium. Indigent mothers and those of borderline economic status may have nursing service at the time of labor and delivery. Eligibility for this service is determined by the county social worker. The physician on the case and the public health nurse confer concerning borderline families and refer them to the social worker, who makes the decisions.

NURSES' TIME SCHEDULE

Each of the two nurses is essentially responsible for the service in half of the county, but the plan is flexible so that each may assist the other. Nursing care at the time of labor and delivery is given

Neighbor returning doctor and public health nurse after delivery. The bad condition of the road is due to a heavy rainstorm

in any part of the county by the nurse who is on call. When this nurse is on a case and a second call comes in, a private duty nurse is employed. The private duty nurse usually goes with the physician and returns with him.

During the regular working day each nurse takes labor and delivery calls in her own area when she is on duty. During the hours from 5 p.m. to 8 a.m. and on Sundays and holidays one nurse is on call at all times. Calls are received in the health unit office during the day when the office is open for business. The nurse leaves with the office secretary the names and addresses of the families to be visited during the day. When there are no telephones in the homes they leave instructions for calls to be sent to drug stores, physicians' offices, or eating places in the section where they are to work during the day. When this plan is not practical, the nurses call into the office every hour or two. At other times the operator in charge at the telephone office transmits messages to the nurse on call.

The health unit endeavors to plan a working week of 44 hours for the maternity nurses which conforms to that of the other health unit personnel.

One of the nurses works all day Saturday and is on call all day Sunday. The second nurse is off duty all day Saturday and Sunday of that week end. They alternate the week ends on duty and off duty. The nurse who has been on duty and on call over the week end is off duty all day the following Monday. They alternate taking time off on holidays. The nurse who remains on call on a holiday is given a day off some time during the month and may take it in conjunction with an off week end, thus giving her three days off in succession. At no time may more than three consecutive days be taken off duty except for vacation, illness, or by special arrangement with the nursing supervisor and the medical director.

When the nurse on call is on a delivery during the hours between 5 p.m. and 8 a.m. she is given time off during the following day to equal the number of

hours she served during the night. But the period off duty never exceeds eight hours—the usual working day.

During a nine-months' period the time was distributed as follows:

5.5 percent of the time on duty during the day was spent on delivery.

.97 percent of the time on call during the night was spent on delivery.

12.7 percent of all the time on duty was spent on delivery.

Less than 1 percent of duty time during the day was spent in compensation for night work. If the nurses had been compensated fully, 2 percent of day-time working hours would have been spent off duty for rest.

An average period of 7 hours was spent on each delivery which was attended by the nurses during the period studied. This included two hours after the birth of the baby, during which nurses were required to remain in the home except in cases when they went with the physician and he left earlier. These instances were infrequent.

Time of occurrence of deliveries is as follows:

8:00 a.m. to 5:00 p.m.—44 percent
5:00 p.m. to 12:00 midnight—15 percent
12:00 midnight to 8:00 a.m.—41 percent

EQUIPMENT CARRIED BY NURSE

The nurses carry a nurse's bag with the following contents:

Bottles
- 1 bottle alcohol, 2 oz.
- 1 bottle liquid soap, 2 oz.
- 1 bottle lysol, 2 oz.

Glass articles
- 3 thermometers
  - 1 mouth
  - 1 rectal (marked R)
  - 1 for baby (marked B)
- 1 medicine dropper
- 1 hypodermic syringe and 2 needles
- 1 De Lee's tracheal catheter

Rubber articles
- 1 pair sterile rubber gloves
- 1 soft rubber catheter
- 1 soft rubber rectal tube

Instruments
- 1 hemostat
- 1 dressing forcep
- 1 tissue forcep
- 1 blunt-end scissors

Enamelware
- 1 covered sterilizing pan, 5″ x 8″
- 1 covered sterilizing pan, 3″ x 8″
- 1 funnel

Linen
- 1 butcher apron in a muslin case
- 1 package of 12 sterile gauze sponges
- 1 package of 2 sterile towels
- 1 package of sterile cotton
- 2 face masks
- 2 packages of sterile cord dressings and ties

Miscellaneous
- Baby scales
- 12 paper towels
- 12 paper napkins
- 3 newspaper bags
- Safety razor
- 1 nail file
- 1 aluminum cup, 8-oz.
- 6 silver nitrate ampules
- 1 tube of vaseline or jelly
- Washable bag linings for frequent changes

OBSTETRICAL PACKAGE

Sterile obstetrical packages are made available to the physicians for use at *all* deliveries in homes without cost to the family. The sterilized package is wrapped in heavy Manila paper, and sealed with two and one-half inch gummed paper tape. The package is dated* and the size of the gloves in the bundle is written thereon.

The packages are kept in a metal cabinet in a central distributing station which is located in the waiting room of a physician in the county-seat town. This office is open at all times. Physicians from all parts of the county may come for packages and return the unexpended articles of used packages.

The physicians select packages with the desired size of gloves. The nurses carry packages in their automobiles and occasionally leave some with a physician when visiting him for other reasons.

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*Editor's Note: The Maternity Center Association recommends that packages which have not been used be resterilized after two weeks.

All is well with mother and baby

The list of contents and cost of each article are as follows:

Doctor's gown	$1.08
Obstetrical drape, with leggings attached	3.95
1 solution basin 12″ in diameter*	3.65
1 placenta basin	.10
1 preparation basin	.10
4 towels	.40
4 cord dressings and ties in paper bag	.06
2 dozen cotton balls	.04
1 pair gloves (rubber)	.11
1 examining glove (rubber)	.06
1 glove envelope	.16
1 package cover	.10
2 bedpads	.10
1 waterproof obstetrical sheet	.16
1 mask	.16
1 baby band (gauze)	.02
8 safety pins	.01
2 dozen vulva pads in paper bag	.25
2 ounces of green soap and bottle	.04
1½ dozen gauze sponges	.14
Total	$10.69

*A Monel metal basin is used. It is believed that the advantages of the metal, which is indestructible and easy to clean, justify the original cost—which is higher than that of most basins.

The Washington County hospital launders and sterilizes all obstetrical supplies.

The laundry cost of articles in the obstetrical package is as follows:

1 gown	$.15
4 towels at 3 cents each	.12
1 face mask	.01
1 glove wrapper	.02
1 pair leggings with sheet	.10
1 package wrapper	.03
Total	$.43

Other laundry costs are:

1 nurse's butcher apron	$.07
1 apron wrapper	.02
1 bed sheet	.10
Total	$.19

The costs of sterilization are:

1 obstetrical package	$.25
1 package of gloves (1 pair)	.05
1 large sack of supplies (packages gauze sponges, cotton balls, etc.)	.10
2 large sacks of supplies	.25
Total	$.65

Mothers' class

EXTRA HELP

A local nonprofessional worker is employed by the health unit on a part-time basis and is assigned to the supply and workroom. Her duties are to assemble and wrap the obstetrical packages; wash stains out of linens; prepare laundry; prepare gloves for sterilization; make pads; mend and sew; keep an adequate supply of obstetrical packages in the central distributing station; and perform such other duties as the nurses assign to her.

The acceptance of the maternity service on the part of families has greatly exceeded expectations. Thirty-six percent of the women delivered in their own homes in 1938 were attended by public health nurses. Seventy percent of the mothers giving birth to babies in 1937 and 75 percent in 1938 were registered for nursing service. The number of home deliveries attended to date in 1939 is greater than in either 1937 or 1938.

The maternity nurses carry all of the family health problems in the homes they visit, but the first approach to the home is always through a maternity patient. The specialized maternity nursing has, however, deprived both the county nurse and the maternity nurses of giving complete family health service and in some instances two nurses visited the same home for different reasons.

GENERALIZED SERVICE PLANNED

Beginning January 1, 1940, a generalized service is to be established in Washington County. Three public health nurses—the two maternity nurses and one nurse now carrying a generalized service—will serve the area. The time on call will thus be lessened for each nurse by one third. The duplication of home visits will be avoided, and a more effective family health service is anticipated.

Nurses now on the generalized service will receive special preparation as soon as it is practical for them. When the present nurses are replaced, nurses having special preparation in maternity nursing will be employed whenever possible.

NURSE PLACEMENT SERVICE

N·P·S CHICAGO announces the following placements from among appointments made in the various fields of public health nursing. As is our custom, consent to publish these has been secured in each case from both nurse and employer.

*Robina Kneebone, Instructor in Nursing and Health Education, Ohio State University, Columbus, Ohio

Dalya Wildebar, Maternal and Child Health Consultant, State Board of Health, Indianapolis, Ind.

*Mrs. Jean McCraney, Advisory Nurse, State Department of Health, Montgomery, Ala.

*Hazel Altmann, Supervising Nurse, District Health Unit, Moline, Ill.

Clarice Purcell, Community Nurse, Harrison County Red Cross Chapter, Clarksburg, W. Va.

Rose Ellen Reed, Staff Nurse, Department of Health Education, South Bend, Ind.

*Dorothy Nelson, School Nurse, Public Schools, Oelwein, Iowa.

*Lena Lundy, Staff Nurse, City Health Department, Fargo, N. Dak.

*Louise Towne, Staff Nurse, Marin County Red Cross Chapter, Fairfax, Calif.

Edna Gilbert, School Nurse, Barre Public Schools, Barre, Vt.

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* Member of the National Organization for Public Health Nursing.

The School Child Washes His Hands

A SURVEY indicates that the majority of school buildings are not equipped with washrooms having adequate facilities for group handwashing. A great many have only a limited number of wash basins for general use. Add to the picture those basins having spring closing faucets and cold water only, no towels, and no soap, and then try to find anything to encourage habits of cleanliness among a group of hungry school children intent on getting to the lunchroom.

Convenience should be the keynote of any layout of washing facilities installed to induce habits of cleanliness among children, and a careful consideration of this point will reduce to the minimum future disciplinary requirements in connection with their use. Washing facilities must do just what the term implies—make the washing operation easy and pleasant, if handwashing before eating is to become a voluntary habit on the part of the child.

We would not advise the use of individual wash basins. Not only would the time required to fill and empty a basin retard the group washing schedule, but the child's natural reluctance thoroughly to cleanse the bowl before leaving it for another's use might partially defeat the object in view. When the necessity to make out with equipment on hand dictates the use of individual hand basins, the waste stoppers should be removed and small spray nozzles installed in place of the faucets. These nozzles should extend three or four inches out from the back of the bowl, and the flow of water through them should be controlled from one point in the room by means of a single temperature and flow control valve.

Among the fixtures that are manufactured especially for group washing, there is one convenient type, circular in form, which has water sprays and soap supply mounted over the center. This fixture provides generous elbow room for the users and is designed to be installed away from the wall, thus allowing ample space for circulation. Another and somewhat similar type of fixture is semicircular in form and is arranged for installation against the wall, a shape that may prove advantageous in some layouts. There are also washing fixtures of the trough type that are manufactured in unit lengths complete with water and soap fittings. These may be assembled and connected up in batteries of any required capacity. Fixtures that are manufactured for adult use should be carefully checked as to height when adapted to the younger grades.

Soap is also an important item in any group washing program, and its convenient distribution must be carefully arranged. The use of other than liquid or powdered soap for group washing introduces difficulties that should be avoided. The principal points to consider are that the dispensing points are of sufficient number to eliminate the necessity of children reaching in front of one another to obtain soap, that the points are at a convenient height for a child's reach, and that the operation of obtaining soap can be performed with one hand. Soap containers should be of glass in order that the contents may be readily inspected, since soap shortage while a group is washing will prove detrimental to the schedule of operation.

Hand-drying is almost as important as handwashing, and several methods have been tried for group work.

Discardable paper towels, issued to each child by means of a dispenser located at the exit end of the washing fixture appear to meet the requirements of convenience and speed. The towels, however, must be of a type that will

Courtesy, Department of Education, Newton, Mass., and The Nation's Schools

actually dry the hands of the child.

In many communities the school authorities, fully cognizant that hand-washing before eating is a phase of the health program that would be reflected in improved attendance records, still hesitate to attempt its inauguration because of an already restricted operating budget. In some cases this financial hazard may be surmounted and the objective gained by a direct appeal to the parent-teacher association or to some other actively interested group, and the program presented as a cleanliness health measure worthy of independent support. By such an approach the initial costs of equipment and the provision of an adequate supply of towels and soap may be shouldered by interested members of the community.

—From "Prelude to Eating," by Aubrey B. Grantham, *The Nation's Schools*, January 1938.

Health in an Agricultural College

By MAIDA ELEANOR HEWITT, R.N.

The health program at North Dakota Agricultural College has developed from a small beginning to an important department of the institution with a building of its own

THE FIRST PATIENT of the day arrives while the nurse is taking off her coat. He limps in wearing a slipper on his afflicted foot, for which the doctor had ordered a hot compress the night before. The infection is no better, so he is put to bed in the infirmary next door where the nurse can apply his compress properly. In the midst of the task the telephone rings, and someone asks, "Is this the health department? Do you know who is supposed to collect the garbage from the home management house?" Having directed this inquiry to the proper agency, and settled her patient with the shades drawn so that he will sleep, the nurse sits down to plan her day.

There are physical examination sheets to be filed from the day before; notices of appointments for rechecking the examinations to be sent out; articles to be sterilized before the doctor comes; two visits to make. The morning passes with various interruptions and after lunch the doctor arrives. He approves the treatment of the patient in bed and admonishes him in regard to wearing new shoes to school. There are five girls to have physical examinations. One is referred to an oculist. One who admits that she went to too many teas during "rush" week is advised regarding the kind of diet and the hours of sleep necessary to clear up her complexion.

After two busy hours, the doctor goes to his delayed lunch and the nurse optimistically goes to work at her files again. But a tall football player walks into the office, sits down heavily, and says, "I don't feel very well, Miss Hewitt. I woke up this morning with a pain right here and it doesn't seem to go away." So Jack goes to town to the doctor's office, since the nurse has learned to mistrust a "pain right here that doesn't go away."

The phone jingles again, and a boy from the fraternity house across the street is calling. One of the "pledges" has been under treatment for a Vincent's infection, and the house manager wants a confirmation of the patient's report that he is well. It seems that in addition to having his dishes boiled, the pledge has been eating by himself in the kitchen and he is now eager to be about in society again.

Now comes the doctor's word that Jack's trouble is acute appendicitis, and will the nurse telephone his father for permission to operate? Since his parents are too far away to arrive this evening, she goes to the hospital after dinner to see that he is really all right. On the same floor there is the tall freshman girl with the incredible eyelashes who fell and fractured her elbow today. She, too, is being well cared for. So home goes the nurse with a light heart and an eye for the last golden light of the sunset behind the elms on the campus.

PERSONAL CONTACT WITH STUDENTS

The work of the nurse in a small college is full of variety. While perhaps she loses something by being out of con-

tact with other members of the profession, there is much to be gained in the experience of working with young, healthy people. At the North Dakota Agricultural College, which has an enrollment of seventeen hundred, the nurse comes to know many of the students and derives much satisfaction from working with them. The deans and other staff members frequently refer students to the physician or the nurse for help with their health problems, and many come of their own accord. An effort is made to aid them with adjustments which are often difficult for young people at college.

The administration of the college health program is in the hands of a committee consisting of the doctor, the nurse, and seven faculty members appointed by the president. This year the committee includes two professors of nutrition, the head of the bacteriology department, the dean of the school of pharmacy, a professor of zoology, and two members of the physical education department. The other faculty committees are new each year, but there are only two changes in the health committee each fall, which makes for more efficient service.

MEDICAL SERVICE AVAILABLE

As early as 1914 the school had the services of a doctor for a few hours each week, and in 1932 a nurse was made a part of the health service.

At the present time the college employs a part-time physician who is a member of a clinic in town. The services of the other members of the clinic are also available to the students. The doctor is in his office at the college for two hours, six days a week, and when necessary students may see him at his office in town without charge. He makes calls at the infirmaries and one house call without charge, but students are expected to pay for house calls after the first one. While physical examinations are being made, he spends as much time at the health service as is necessary. Students are at all times encouraged to go to their family physician or to choose their own doctor when in need of medical attention other than the physical examination.

There is a two-bed infirmary in each of the two dormitories. These are used for patients with minor illness and for students who are under observation pending diagnosis. Students with communicable diseases are not cared for in these infirmaries, but are sent to the city isolation hospital.

Physical examinations are required of all new students, and the physical education department coöperates in scheduling these and seeing that students keep their appointments. Since there is only one physician, it is important that the examinations be carefully planned for in order to get them all finished. In the examination, note is taken of defects which can be remedied and recommendations are made to the student regarding correction. Later these students are called back for rechecking.

The physical education program is planned so that all may participate. Adaptations are made to the needs of individual students. Very few are excused from physical education. This year the doctor is especially careful about exemptions of women students, since the department expects to carry out a program in which there will be a part for any girl who is well enough to be in school. Thus the girl with a heart murmur who is not able to do tap dancing may find recreation and relaxation in archery.

TESTS AND IMMUNIZATIONS

Wassermann and Mantoux tests are not required as a part of the examination but students are encouraged to have them made. Since the college is a state institution, the Wassermann tests are done free of charge in the state laboratory. The college is also furnished with

smallpox and typhoid fever vaccine, Schick toxin, and diphtheria toxoid. Since smallpox vaccination is not compulsory in North Dakota, a number of unvaccinated people are found entering college. During the winter quarter last year the nurse contributed to a health column in the college newspaper, and used that means to acquaint the students with the uses they might make of the health service for immunization, Mantoux tests, and Wassermann tests.

Formerly, routine laboratory work for the health service was carried on in the bacteriology department by a technician who was employed for that purpose. The plan this year is to have the work done by senior students in bacteriology and pharmacy. Special laboratory work will be done at the doctor's clinic in town or at one of the hospitals. Fargo has two excellent hospitals, both of which offer hospitalization and laboratory and x-ray service to students at special rates. The department of pharmacy at the college supplies drugs at a nominal cost.

A three-hour course in hygiene, arranged under the auspices of the physical education department, is required of freshmen. The lectures are given by persons in that department, the doctor, the nurse, a nutritionist, and a physiologist. An effort is made to offer a course which will be of practical help in the students' problems; to do away with the unsound beliefs about health which are often a result of propaganda in advertising; to teach that good health is a state of mind as well as of body; to acquaint students with the fundamental principles of nutrition which will enable them to choose foods wisely; and to teach the physiology of the reproductive system, about which even college students have vague and erroneous ideas.

This year marks an important step in the development of the health program. A new building to house the health service is under construction. During past years the department has been located in one of the dormitories on the campus. The new health center is being built with an eye to the future, when new wings may be added. The present plan will provide for a waiting room, doctor's office, laboratory, six infirmary beds, kitchen and nurse's quarters.

The college is fortunate in having as president a man who knows the importance of health education. From the health department, beginning as a kind of stepchild in the college, it is growing into its place as a necessary part of the institution. The health program is still young, but plans for its growth are maturing, and next year will see greater things.

A student visits the health center

New Jersey Surveys Orthopedic Nursing

By MARY NEVIN, R.N.

Intelligent program planning is based on a knowledge of existing needs and resources. New Jersey studies its facilities for nursing care of its crippled children

A SPECIAL SURVEY of the facilities for the care of crippled children available through public health nursing agencies in the state was made by the New Jersey Crippled Children Commission in 1938.

This Commission was created by Act of the Legislature in 1926, as a separate department of the state government, administered by ten unsalaried commissioners appointed by the governor. The chairman of the Commission is also its executive director. Its work has been supported by funds from the state, from the twenty-one counties, from local Elks' lodges, and from other organizations represented on the Commission—to which sources of support are now added the federal social security appropriations.

When the Social Security Act became effective in New Jersey, the Commission enlarged its staff and extended its program for the care of crippled children. It added to its staff an orthopedic public health nursing supervisor, two orthopedic public health nursing consultants, and three local orthopedic nurses. It was purposed to provide nursing care for the more than 10,000 patients in the Commission's files, through existing agencies, coördinated and assisted by the Commission's own staff. However, it was soon apparent that available information on existing nursing facilities which might be utilized to care for crippled children was so inadequate that the Commission could not intelligently plan an orthopedic program.

In consequence it undertook to secure this information through a survey of the public health nursing agencies in the state, planned and carried out with the assistance of the public health nursing consultant of the United States Children's Bureau for this area, and the Advisory Committee to the Crippled Children's Commission of the State Organization for Public Health Nursing.

METHOD AND SCOPE OF SURVEY

The survey was made by the questionnaire method. The principal executive of each of the agencies surveyed was interviewed by the supervisor, or by one of the five nurses on the staff of the Commission—except in two instances when a number of affiliated agencies were covered in a single interview. The basis of these interviews was a questionnaire which sought to obtain information about each agency under the following headings:

Distribution of nursing services in the state
Source of funds
Personnel
Affiliation with schools of nursing
Orthopedic qualifications of personnel
Records of cases and visits
Cost of nursing visits and fees charged
Transportation of crippled children
Orthopedic nursing program

The survey included 71 agencies, of which 50 were visiting nurse associations and American Red Cross services. It was planned to include all visiting nurse associations and Red Cross nursing services in the state, of which there were 65 in April 1938; however, only fifty reports were obtained due to the fact that

two counties each reported as single units rather than by separate agencies in the counties. In addition, the survey included 11 municipal health departments, 1 municipal welfare department, 1 county health department, 1 county welfare board, 1 county health and welfare agency, 3 county tuberculosis associations, 2 industrial nursing agencies, and 1 specialized child welfare agency—all of which were known to employ public health nurses and which might be giving orthopedic nursing care. Since the functions of child hygiene nurses and school nurses in the state do not include bedside nursing and since the services of insurance nurses are restricted to policyholders, these groups were not included in the survey.

FINDINGS OF THE SURVEY

The results of the survey are briefly summarized below under the subjects considered:

Distribution of nursing services

There are 563 municipalities in New Jersey. Visiting nurse service is available in 301 municipalities, containing 83 percent of the state's population. The 262 municipalities in which visiting nurse service is not available are largely rural; they contain only 17 percent of the population of the state but include about 60 percent of the area.

Five counties are entirely covered by visiting nurse services. Three rural counties with a total population of 111,877 have no visiting nurse services whatsoever, but are served by child hygiene and school nurses.

In many areas where visiting nurse service is available, the nursing personnel is inadequate in terms of population served and territory covered. Also, some agencies restrict their services to pay patients in part of the area they cover. These considerations were not included in the survey.

Source of funds

Of the 71 agencies surveyed, 69 reported the source of their funds as follows:

13—supported entirely by public funds.
17—supported entirely by private funds.
39—supported by both public and private funds.

In the 39 agencies supported jointly by public and private funds, it appears that about 60 percent of the support is received from private sources and 40 percent from public sources.

Personnel

The professional personnel employed by the 71 agencies surveyed consists of 353 full-time and 7 part-time public health nurses including 19 directors, 6 educational directors, and 36 general supervisors. Only 8 agencies employ specialized supervisors, and 4 of these are on part time. Of the field nurses, 252 are employed for generalized public health nursing and 36 in specialized programs.

No agency employs a supervisor or consultant in orthopedic nursing. Two agencies employ a field nurse for special orthopedic service, but one of these is used only part time for this work.

Affiliation with schools of nursing

Five agencies accept students from schools of nursing for field practice in public health nursing. During 1937 86 students received this training. The time spent in the field work varied from one to three months.

Two of these agencies also accepted students from public health courses in universities. In 1937, there were 11 students who received this training for periods of from two to ten months.

Orthopedic qualifications of personnel

Information was obtained about the qualifications for orthopedic nursing of the public health nurses even though they were not employed in that specialized capacity. Ten agencies have on their staffs 10 supervisors and 14 field nurses who have had either courses or experience in orthopedic nursing since

graduation. However, it must be noted that the preparation represented in this group does not in most cases meet the qualifications recommended by the National Organization for Public Health Nursing.*

Records of cases and visits

About two thirds, or 46, of the agencies surveyed kept records of cases and visits for all types of cases. Thirteen agencies recorded visits only and 12 agencies recorded neither visits nor cases. These 12 agencies include five visiting nurse services; four municipal health departments; one department of welfare, and two industrial nursing services. Only 9 agencies kept separate records of orthopedic cases and visits. Two agencies kept separate records of orthopedic cases only and 2 of visits only.

Several agencies plan to change their record systems to conform to the recommendations of the National Organization for Public Health Nursing.** Sixty-three agencies agreed to report new cases on forms provided by the State Crippled Children Commission and to furnish the Commission with monthly reports of cases and visits to crippled children.

Cost of nursing visits and fees charged

Of the 71 agencies surveyed, 16 are county or municipal agencies which make no charge for nursing visits. The remaining 55 private agencies all charge for nursing visits, but 11 make no computation of cost per visit. Forty-four compute their cost per visit on an annual basis by the method recommended by the N.O.P.H.N.***

The cost per visit for the 44 agencies which computed a cost per visit ranged from 75 cents to $1.75, and the median was $1.03. The cost was under $1 for 19 agencies and over $1 for 25 agencies. The fee charged does not coincide with the cost per visit.

Thirty-nine agencies charged a fee of $1 for a full paying visit. The other 16 agencies charged fees ranging from 50 cents to $2.

Forty-four agencies have schedules of fees for special treatments. Nineteen agencies have hourly rates for special services.

Transportation of crippled children

Fifty-eight of the 71 agencies arrange for the transportation of crippled children to and from clinics, and 13 agencies assume no responsibility. Of the agencies which secure transportation, 11 use their own staffs, 25 use volunteers, and 22 use both staff and volunteers.

Of the agencies reporting, 24 count transportation as "nursing visits" and 34 do not.

Orthopedic nursing program

Out of 71 agencies, 56 gave general bedside care to crippled children. Only one of the visiting nurse agencies, a county Red Cross nursing service, did not give bedside care. Other agencies offering bedside care were:

1 industrial nursing service
1 county health and welfare department
5 municipal health departments

Almost 80 percent of the agencies stated that they gave orthopedic nursing care, but examination shows considerable variation in the extent and kind of care. While they all gave general bedside care, less than two thirds offered bedside care for acute poliomyelitis, and about the same number offered nursing advice and instructions about orthopedic conditions. Assistance in the purchase and adjustment of orthopedic appliances was given by one third of the agencies, and only a

* National Organization for Public Health Nursing. "Qualifications of Nurse in Orthopedic Program." PUBLIC HEALTH NURSING, April 1939, p. 233.

** National Organization for Public Health Nursing. Suggestions for Statistical Reporting and Cost Computation in Public Health Nursing. The Organization, 50 West 50 Street, New York, 1937.

*** *Ibid.*

few more made arrangements for convalescent care. Only 19 agencies provided massage, and 7 provided supervision of corrective exercises. No agency was equipped to provide muscle grading and reëducation.

Upon inquiry, 63 agencies stated that they would be interested in availing themselves of orthopedic nursing consultation if it was offered by the Crippled Children Commission. The remaining 8 agencies did not consider orthopedic services properly within the scope of their programs.

Additional visiting nurse services are needed, especially in the rural sections of the state.

The keeping of more adequate records of crippled children's services by visiting nurse agencies will be necessary before it will be possible to estimate even the number of orthopedic cases under care or the amount of care given.

Orthopedic nursing programs, which are generally inadequate, should be expanded and standardized in order to provide better quality and continuity of care of crippled children.

Facilities for preparing nurses in public health work as well as in orthopedic nursing must be increased in order to improve orthopedic programs.

Arrangements can usually be made for the transportation of crippled children to and from places of treatment.

Nursing agencies are well disposed to coöperate in improving orthopedic nursing facilities insofar as resources permit.

Copies of the complete survey may be obtained from the New Jersey Crippled Children Commission, 732 Broad Street Bank Building, Trenton, New Jersey.

Your N.O.P.H.N.

IN SEPTEMBER 1929—the morning of September 15, to be exact—a lay person was employed on the staff of the National Organization for Public Health Nursing. This was a new departure for the organization. For two years the Board of Directors had studied the advisability of having a lay section in the National, and the plan for the new section had been agreed upon at the Biennial Convention in 1928. The lay section then asked the National for their secretary—for someone to help them with their job of being better board and committee members of local public health nursing programs.

Of course there had been lay members of the professional staff. The statistician and the business manager were not public health nurses, but they were specialists in their particular fields. This new staff member was a "lay layman" as someone called her. Her equipment for the job consisted of having been a board member and a volunteer worker for many years, and also having worked for the centralization of volunteer efforts under a council of social agencies.

When the prospective staff member interviewed the general director of the N.O.P.H.N. regarding the position, her feeling was that at long last here was the job she had always felt should be done. It has always seemed to her important that there be someone who could help interpret the lay and professional workers to each other.

Just what the program should be, no one really knew. How it should be done was uncertain. There were no patterns to follow; no traditions established. In fact, no other social or health field had tried it. Fortunately, the new lay secretary had a sympathetic and understanding staff of co-workers

who had unlimited patience with her many questions. She also had a lay chairman and an executive committee of the lay section who gave her untiring help. It is to people such as Mrs. Whitman Cross, Mrs. C.-E. A. Winslow, and the late Gertrude Peabody that credit must go for making the development of this program possible.

The first thing that was needed was to learn the problems of board members, and for this purpose, field trips have been made all over the country. In fact, only five states—Montana, North Dakota, South Dakota, Wyoming, and Nevada—have not been visited by the lay staff member. Some of these five will be visited this spring. Conferences have been held with public health nurses in states, cities, and rural areas. Board and committee meetings have been attended in large cities and in far remote towns in this country. The thing that impresses the lay secretary everywhere she goes is that the laymen want to be of help and the public health nurse needs their help. In order that the layman *can* be of assistance, he must find out how he can serve best, and the public health nurse must be ready and willing to use this service.

The program for the lay group during these past years has fallen rather roughly under the following headings:

1. *Organization and function of a board or committee.* An effort has been made to answer questions relative to these problems through the *Board Members' Manual,* published in 1930, and revised in 1937. Also, many discussion meetings on this subject have been held—10 in Massachusetts, 4 in New Jersey, 4 in Pennsylvania, 2 in Connecticut, 1 each in Ohio, New Hampshire, and Colorado, and 5 in New York City.

More could profitably be held, because it has seemed valuable to board members to sit down together and discuss their mutual problems. Letters come to the office daily asking for help on questions such as the revision of the constitution and by-laws; personnel policies; the rotation of officers; and whether men should be included on boards. Also, as a part of interpreting public health nursing, the secretary collects materials—pictures, radio skits, annual reports—which can be of help to local groups in telling the story of their work. Much of the available material is listed currently in the N.O.P.H.N.'s Publication List.

2. *Board Education.* This is a subject about which there has been a great deal of discussion. Board members who are familiar with public health nursing say they are tired of hearing people say board members should be educated. Others have said they disliked having efforts made to educate them. On the other hand, new members elected to boards welcome an opportunity to know more about the work of the agency, about public health nursing, and about their job as board members. Interest in a program seems to go along with knowledge. Board education is adult education in a given field. No one believes today that education stops with school, college, or professional school. It is a life process. Keeping in touch with public health developments requires study, and board membership is not a pastime today. It is a real job. Therefore, various courses have been outlined, and help has been given along these lines.

3. *Volunteer workers.* Training courses for volunteer jobs have been prepared. Studies on volunteer service in public health nursing agencies have been made, and direct service has been given in assisting local agencies to outline possible volunteer programs.

4. *Lay committees for public health organizations.* Lay committees for public health organizations supported by tax funds have greatly increased in

number recently. For many years, nursing committees for the nurse working by herself in a rural area have been encouraged, and many states have excellent committees functioning in this capacity. With the enlarged health program under the Social Security Act, it seems very important to have advisory committees working with the whole health department in order to interpret the program to the community. Both the Children's Bureau and the United States Public Health Service are interested in furthering this type of committee. The N.O.P.H.N. has gathered material prepared by some states to promote this type of committee and has made it available in loan folders. The revised *Board Members' Manual* has a chapter on citizen participation in the tax-supported agency. Articles have appeared in PUBLIC HEALTH NURSING magazine, and definite material has been prepared for the organization of such committees.

Recently a series of discussion meetings was held for all the personnel of local health departments—health officers, public health engineering officers, and public health nurses—to discuss the value of a committee, how to organize one, and what the committee may do. These meetings were sponsored in one state by the state health department, in another by the state organization for public health nursing and state health department. Requests are coming in for other meetings of this kind.

5. *Talks to students taking programs of study in public health nursing.* Lay committees are of little value unless the professional worker is thoroughly convinced of their need and knows how to work with them. To this end, talks on the N.O.P.H.N. board members' program have been given to students in the university programs of study. These have covered periods from two to eight hours in length. Perhaps the subject should be studied in even greater detail, and the possibility of a one-hour semester course on community relations has been discussed. This course would cover the relationship of the nurse to other social agencies, to other professional groups, and to lay groups, as well as the relationships to the board, committee, and volunteer worker.

6. *State organizations for public health nursing.* Assistance is given to S.O.P.H.N.'s in the development of their lay sections. The more the board and committee members of local agencies can meet with public health nurses on a statewide basis, the broader will be their knowledge of the public health nursing field. Developing lay support of state programs is extremely important, and the S.O.P.H.N. is valuable in bringing the lay person and the professional together.

7. *Coöperation with other fields.* Other national agencies are more and more interested in furthering lay participation. Because of the experience the N.O.P.H.N. has been able to gather through these ten years, its material is often used by other agencies. The lay secretary is a member of committees of the National League of Nursing Education, the National Conference of Social Work, the Association of the Junior Leagues of America, and the National Committee on Volunteers in Social Work.

Progress has been made in the more effective use of the laymen in the field of public health nursing, but there is still much to do. When the job was first undertaken, the secretary little thought that she would stay ten years. However, the pleasure of working with both public health nurses and laymen in furthering the cause of public health is a continual challenge.

EVELYN K. DAVIS

This is the fourth of a series of articles on the National Organization for Public Health Nursing, written by the president and members of the staff.

NOTES *from the* NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING

DR. LIVINGSTON FARRAND

Dr. Farrand, a member of the N.O.P.H.N. Advisory Council and a friend of all nurses everywhere, died in New York City on November 8. The editorial comment in the *New York Herald Tribune* that "despite his high office Dr. Farrand never lost his simple outlook on life nor his ability to see a question from the average man's point of view" well describes his rare ability to understand nursing problems. He shared in many of our conventions, served on our national committees, and wrote for our magazine. Most helpful of all, he had the gift of seeming to have all the time in the world to devote to an individual problem. Many a nurse and many an organization went to him in trouble and never failed to find help. His death is a genuine loss to us all and to our profession.

N.O.P.H.N. DINNER

Two hundred and sixty people, most of whom were public health nurses, attended the N.O.P.H.N. dinner which was held the night preceding the annual meeting of the American Public Health Association in Pittsburgh, Pa., in the Chatterbox Room of the William Penn Hotel. The tables were most attractively decorated with flowers provided by the Pittsburgh Public Health Nursing Association. Dr. C.-E. A. Winslow, chairman of the N.O.P.H.N. Advisory Council, presided at the dinner and Katharine Tucker, director of the Department of Nursing Education of the School of Education of the University of Pennsylvania, was the chief speaker. Her address was published in the November issue of PUBLIC HEALTH NURSING (page 606) under the title, "Preparation of the Public Health Nurse." Elizabeth Smellie, chief superintendent of the Victorian Order of Nurses for Canada, brought greetings from her country. Public health nurses will be delighted to know that Miss Smellie has been elected first vice-president of the American Public Health Association.

WITH THE STAFF

Dorothy Deming made two short visits to Washington, D.C., during November. She attended on November 15 one of the group meetings called to plan for the White House Conference on Children in a Democracy called by the U. S. Children's Bureau, and on November 24 she was present at the meeting of the National Committee on Red Cross Nursing Service.

Purcelle Peck spent the last two weeks of November in the South, during which time she attended and spoke at two S.O.P.H.N. meetings—the Georgia S.O.P.H.N. in Savannah, November 12, 13, and 14; and the Louisiana S.O.P.H.N. in Shreveport, November 21 and 22.

Evelyn Davis conducted a series of discussion meetings for delegates from corporate agencies in or near New York City, on November 8, 13, 14, 15, and 16. On November 22, she went to Hartford, Conn., to attend an institute for board members under the auspices of the Visiting Nurse Association. She spent November 27 in Jersey City, N.J., giving a talk at one of a series of lectures on the volunteer program, under the auspices of the Council of Social Agencies.

Virginia Jones went far afield during November. She was in California from

November 4 to 25. In Los Angeles, she visited the course at the University of California and attended the board meeting of the new visiting nurse association. She attended the annual meeting of the Visiting Nurses of San Diego on the thirteenth. The rest of her California itinerary was planned by Ruth Hay, president of the California S.O.P.H.N., and Rena Haig, chief, Public Health Nursing Service of the State Department of Public Health. From California she went to Portland, Ore., on November 25 to spend a week in that state. While there she visited the course at the University of Oregon and conferred with the director of the Division of Public Health Nursing of the State Board of Health.

On October 31 and November 1, Ella Pensinger gave consultation service to the Visiting Nurse Association in New Canaan, Conn.

Our newest staff member, Jessie Stevenson, went to Washington, D.C., on November 2 to join a conference with representatives of the U. S. Children's Bureau in regard to the N.O.P.H.N. program for orthopedic nursing, and again to Washington on November 30 to attend the meeting of the public health nursing advisory committee called by the U. S. Children's Bureau.

HONOR ROLL

Hearty thanks and congratulations to our 940 Honor Roll Agencies for 1939! Each one of you has done a large part in making this the banner Honor Roll year of all times. We are proud of this achievement and very grateful to you.

This is the last list to be published in 1939, but there is still time to write in and get your Certificate (if your staff is 100 percent enrolled) and have the name of your staff added to the complete list which will appear in the next issue of *Listening In*.

ALABAMA
Kate Duncan Smith, D.A.R. School, Grant

ARIZONA
Coconino County Health Service, Flagstaff

ARKANSAS
Poinsett County Health Department, Harrisburg

CALIFORNIA
Metropolitan Life Insurance Nursing Service, Fresno
*Santa Barbara County Health Department, Santa Barbara

CONNECTICUT
*Visiting Nurse Association of Hartford, Hartford
*Visiting Nurse Association of Stamford, Stamford

FLORIDA
Monroe County Health Department, Key West
Hillsborough County Health Department, Tampa

IOWA
Independent School District, Clinton
District Health Service No. 4, State Department of Health, Fort Dodge
Metropolitan Life Insurance Nursing Service, Keokuk

MISSOURI
St. Louis County Health Department, Clayton

NEW JERSEY
Board of Education, Clifton
*Perth Amboy Chapter, American Red Cross, Perth Amboy

NEW MEXICO
Union County Department of Public Health, Clayton

NEW YORK
*Erie County Health Service, Buffalo
Metropolitan Life Insurance Nursing Service, Fulton

OKLAHOMA
Cleveland County Health Unit, Moore
Normal Public School, Norman

PENNSYLVANIA
Lansdale Community Service, Lansdale
Lebanon Valley Visiting Nurse Association, Robesonia

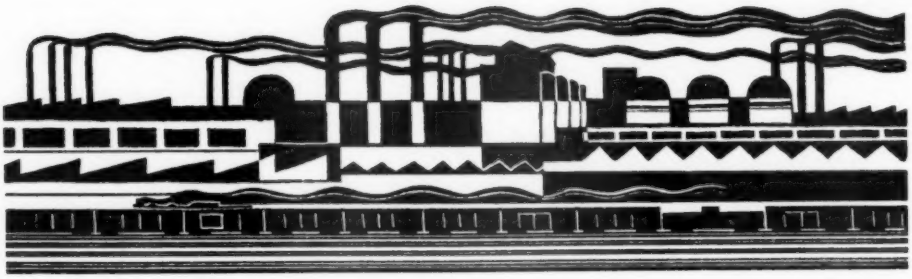
WYOMING
Casper Board of Education, District No. 2, Casper
Natrona County High School, Casper

*Agencies which have been on the Honor Roll list for five years or more.

PHILADELPHIA HOTEL INFORMATION

Biennial Convention, May 12-18, 1940

HOTEL	ACCOMMODATIONS	RATES
Adelphia 13th and Chestnut	Single with bath Double with bath	$4.00 5.50 to $ 8.00
Barclay Rittenhouse Square, East	Double with bath	6.00 to 10.00
Belgravia 1811 Chestnut	Single with bath Double with bath	3.00 5.00 to 6.00
Bellevue-Stratford (Headquarters of N.O.P.H.N.) Broad and Walnut	Single without bath Single with bath Double with bath	2.50 3.50 to 4.40 5.00 to 8.00
Benjamin Franklin (Headquarters of A.N.A. and N.L.N.E.) 9th and Chestnut	Single with bath Double with bath	3.50 to 5.00 5.00 to 7.00
Chateau Crillon Rittenhouse Square	Single with bath Double with bath	4.00 6.00
Douglas (Colored) Broad and Lombard	Single without bath Double without bath	2.00 2.50
Drake 1512 Spruce	Single with bath Double with bath	3.50 5.00 to 6.00
Essex 13th and Filbert	Single with bath Double with bath	2.75 to 3.25 4.50 to 5.50
Normandie 36th and Chestnut	Single without bath Single with bath Double without bath Double with bath	2.00 2.50 3.00 4.00 to 4.50
Philadelphian 39th and Chestnut	Single with bath Double with bath	2.50 4.00 to 5.00
Rittenhouse 22nd and Chestnut	Single without bath Single with bath Double without bath Double with bath	2.00 to 2.25 2.25 to 2.50 3.00 3.50 to 5.00
Ritz-Carlton Broad and Walnut	Single with bath Double with bath	4.40 to 5.50 6.60 to 8.80
Robert Morris 17th and Arch	Single with bath Double with bath	2.50 to 3.50 3.50 to 5.00
St. James 13th and Walnut	Double with bath	5.00
Stephen Girard 2027 Chestnut	Double with bath	5.00
Sylvania Juniper and Locust	Single with bath Double with bath	2.50 4.50
Walton Broad and Locust	Single without bath Single with bath Double without bath Double with bath	2.00 to 2.50 2.50 3.00 to 3.50 4.00 to 7.00
Warwick 17th and Locust	Double with bath	7.00 to 8.00
Wellington 19th and Walnut	Double with bath	6.00
Y.M.C.A. 1425 Arch	Single without bath Double without bath	1.00 to 1.25 2.00 to 2.50



THE INDUSTRIAL NURSE'S EQUIPMENT FOR HER JOB

THE INDUSTRIAL nurse needs a broad knowledge of factors affecting the health of the worker and she must be equipped to carry on a variety of activities in the plant. The following list of things which the nurse should be familiar with are listed by Dr. M. H. Kronenberg, in a discussion of the industrial nurse's functions at the spring meeting of the Illinois Industrial Nurse's Association. Dr. Kronenberg is chief of the Division of Industrial Hygiene of the Illinois State Department of Health. The nurse should have an understanding of these factors in industrial health:

Environmental factors

Material exposures in the plant and their effect on health

Ventilation requirements

Effects of abnormal humidity and heat on the worker

Problems of illumination, which is a factor in reducing accidents, eye-strain, and bodily fatigue

Noise in industry—its effect on the auditory system and the nervous system

Proper seating—especially where women employees are concerned

Washroom facilities—their adequacy and maintenance

Rest-room quarters for rest periods—needed especially for women employees

Regulations regarding hours of work, particularly for women and for young adult workers

Industrial fatigue

Monotonous and repetitious occupations, and their effect on the physical and mental health of workers

The health of the individual worker

Health education for employees, individually or in groups, through posters, bulletins, and other media

Nutrition and diet, and their relation to the workers' health

Dental care, with the elimination of foci of infection which may lead to impairments of health

Mental hygiene—especially important in the placement of new employees

Control of syphilis and gonorrhea—as a community health measure

Communicable-disease control — important especially in the control of epidemics

Control of industrial tuberculosis

Community activities and assistance available for the worker

Compensation—diseases which are compensable

Relationships

Industrial relations (The nurse is the liaison officer between employee and employer in many instances.)

Human relations (She is the confidente of the worker, and his friend and counselor.)

Professional, technical, and social-service relationships.

The nurse should be aware of the role of women in industry. Since many have a dual role—that of homemaker and producer—they are biologically not equal to the task of many industrial occupations.

Activities

Keeping of uniform and adequate absenteeism records, which may aid in uncovering sources of ill health of epidemiological importance.

Home visits to sick and injured employees.

CONTROL OF SYPHILIS AMONG EMPLOYEES

THE United States Public Health Service advocates a six-point program to prevent the spread of syphilis among employees in industry as follows:

1. Routine blood tests for applicants for employment.
2. Routine blood tests at the time of periodic re-examination of employees.
3. Industry, with its compact organization, should develop a vigorous educational program.
4. Industry should extend its educational campaign into the field of prophylaxis.
5. There is a responsibility upon the industrial medical officer to see that adequate modern treatment is available to employees at prices ordinary wage earners can afford. If such treatment is not available in private practice or at public clinics, industrial medical service should undertake such treatment.
6. Syphilis must at all times be handled as merely another communicable disease. The privacy of relations between the worker and the medical service should be preserved in the best professional tradition. In ordinary cases syphilis cannot be regarded as ground for discrimination of any kind against employees, when treatment is properly required.

Dr. R. A. Vonderlehr, Assistant Surgeon General in charge of the Division of Venereal Diseases, states that when syphilis cases are given proper treatment, industry runs a minimum of risk of having workers disabled or partially disabled from the disease. A recent survey showed that symptoms of syphilis of the nervous system resulted in only 1.6 percent of the properly treated cases under observation. For untreated cases the rate was 16.9 percent.

These studies also revealed no cases of syphilitic heart disease among the group that had received proper treatment, while 3.4 percent of the cases having no treatment developed heart trouble during the ten- to twenty-year observation period.

"Fortunately," Dr. Vonderlehr says, "some of the larger industries have discovered that the control of venereal diseases in industry can hardly be accomplished by dismissals. They assure the worker that so long as proper precautions are taken during the early stages and proper treatment continued, there will be no dismissals following discovery and treatment of infection.

"Remember, also, that from the public point of view, the patient's continuance of treatment and, therefore, his cure will depend upon the continuance of his income. Nobody would benefit by his discharge. He might easily be thrown upon public relief. That might result from a policy of needlessly discharging syphilitics from their employment.

"The syphilitic person passes through three definite stages: early, latent or symptomless, and late syphilis. If adequate treatment is given to the infected individual, the manifestations of late syphilis are prevented in more than 80 percent of all cases.

"From the standpoint of incapacitation as a result of syphilis with reference to employment, it should be noted that only those people with very early syphilis—in the first week or two of the disease—and those who have manifestations of late syphilis, might have a lowered earning capacity. The number of syphilitic persons in these categories, however, would not constitute more than 10 percent of all the syphilitics in the United States."

The greatest proportion of people so infected, Dr. Vonderlehr explained, have the latent or symptomless form of the disease. Thus, unless a special attempt were made to detect the disease through the use of serological blood tests, the average employer would not be able to tell which of his workers were infected.

Industrial Nurse: See also pages 676, 677, and 718.

PENNY MARSH, SUPERVISOR OF PUBLIC HEALTH NURSES

By Dorothy Deming. 303 pp. Dodd, Mead and Company, New York, 1939. $2.

This is a career book with special appeal to prospective nursing students and those who are interested in public health nursing as a vocation. Because of the juvenile style, this fast-moving, interesting, but rather improbable story is obviously not intended to be used as a source book for graduate nurses in the public health field who may be interested in taking up supervisory work.

Penny, whose adventures as a staff nurse and rural nurse were described in a previous book, continues her career in a big city. Here she learns to be a supervisor of public health nurses. The book is charmingly illustrated with nine sketches of incidents of Penny's full life.

The ingenious weaving of vocational information on public health nursing throughout the story is excellent. Information is included on the following: professional and personal requirements and how to fulfill them; functions in different types of work; record-keeping, with enlightening illustrations; staff-education methods for general staff and individual improvement; planning experiences for the nursing student in the undergraduate school of nursing; public relations programs; the place of volunteer workers; how to live a balanced life; how to secure a position; and the range of salaries in this field.

The incidental reference to public health nursing leaders and a listing of their contributions through writings should be especially helpful to the nursing student who is interested in public health nursing as a vocation.

A student nurse's point of view is expressed in the following review.

EUGENIA K. SPALDING
The Catholic University of America
Washington, D.C.

. . . . . .

Miss Deming in her latest book on public health nursing clearly shows the student and graduate nurse the purpose and the administration of the work carried on by the visiting nurse association. More important, the author shows the satisfaction to be gained by the nurse in seeing her patients, the majority of whom are medically indigent, improve under watchful care; in teaching them important facts for maintaining their health and protecting their families from disease.

There is a personal satisfaction in knowing "there is more joy in giving than receiving." From my own—a student's—viewpoint the book is inspiring, educational, and immensely interesting.

DOROTHY LEE KINES, *Senior Student*
School of Nursing Education
The Catholic University of America
Washington, D.C.

THE PSYCHOLOGICAL ASPECTS OF PEDIATRIC PRACTICE

By Benjamin Spock, M.D. and Mabel Huschka, M.D. Reproduced through the courtesy of the D. Appleton-Century Company from the Practitioners Library of Medicine and Surgery, Vol. XIII, pp. 757-808, by the New York State Committee on Mental Hygiene of the State Charities Aid Association, 105 East 22 Street, New York City, 1938. 25c.

This material has been described by a group of public health nurses—who have already put it to use in their agency—as the sanest and also the most stimulating material of the kind which they have come across. The discussion, which is now available in pamphlet form, was originally prepared for the

use of the general practitioner. Its point of emphasis is that neuroses can be traced back to commonplace, often innocent appearing deviations from healthy functioning in such matters as infant feeding, weaning, toileting. The authors have been specific in discussing the emotional effect of these and like experiences on infants and children, and have discussed some of the difficulties which frequently arise when these experiences have been unhappy ones.

It seems almost self-evident that not only the physician but the public health nurse functions in relation to these same matters, and they will have renewed significance and interest to her after a study of this material. While those who are not entirely sympathetic to the Freudian point of view will perhaps question certain details, it is believed that they too will welcome the presentation as a whole, in this concise and usable form.

RUTH GILBERT, R.N.
Hartford, Connecticut

TAKING CARE OF THE FAMILY'S HEALTH

By Elma Rood and Gertrude Lingham. 2 vol., 597 pp. The Rural Press, 1938. Paper $5, fabricoid $6.50.

Books for public health nurses have been written with the hope that the content could be adapted to situations peculiar to the rural field, but comparatively few books have been confined specifically to the problems confronting the rural health worker. The material in this teaching guide is planned to meet the need of health teachers in a rural community of any size. Although it would seem that the authors intended the manual to be used largely by public health nurses, they suggest that it may be useful also to the teacher of home economics who is working with a public health nurse.

The first volume deals with The Family in Health, and the second includes The Family in Illness and The Family and Public Health. The positive approach is maintained throughout, and the modern concept of teaching families to keep well precedes any attempt to teach the care of the ill. The suggestions, lesson outlines, diagrams, and pictures are clear, comprehensive, and practical. An imaginary family is used to illustrate each unit, and typical rural situations are presented to provide a more realistic interpretation and understanding.

The portion of the book which deals with The Family and Public Health will be of particular interest to the public health nurse. Under this heading are outlined valuable suggestions on how to acquaint the community with the function of the health department, and also how to stimulate the participation of lay groups in community health activities.

With the excellent amount of source material included in this book, one wonders if it might not have been made even more valuable with a bibliography. Although the price slightly exceeds that of many text and reference books, the wealth of material offered justifies the expenditure.

VIRGINIA B. ELLIMAN, R.N.
Washington, D.C.

MEDICAL INFORMATION FOR SOCIAL WORKERS

By William M. Champion, M.D. 529 pp. William Wood and Company, Baltimore, 1938. $4.

This book has been written as a handbook of medical information for students in social work.

It is excellent, but in the opinion of the reviewer, its place is in the hands of those with a wide background of medical information. One is struck by the detailed description of the etiology of diseases which might be very dangerous and lead the lay person to feel that he is equipped to diagnose, and in certain instances even to initiate treatment. There is a dearth of information stressing the implications of disease conditions, which seems more important than the

discussion of diagnosis and treatment.

In a very brief discussion of enuresis, the author outlines the treatment which has been discontinued by forward-looking child guidance centers.

As a handbook of up-to-date medical information for medical social workers one could not seek for more information at so small an outlay.

MILENKA HERC, R.N.
Detroit, Michigan

TUBERCULOSIS AMONG YOUNG WOMEN

By Edna E. Nicholson. 67 pp. National Tuberculosis Association, 50 West 50 Street, New York. Combined and revised edition, 1938. 25 cents.

Tuberculosis death rates among young women are still considerably higher than those for young men. This booklet contains the combined reports of studies of this problem which were made in Detroit and New York in 1932 and 1933. The lack of correlation of tuberculosis mortality with the industrialization of women, degree of education, and other environmental factors is emphasized. Early marriages and early childbearing were found to be related to the onset of tuberculosis. But the main factor in the high mortality rates for young women seemed to be the psychic and physical changes of adolescence and early adult life. In order to save the lives of some of this group, periodic examinations and a more widespread knowledge of early symptoms of the disease are recommended.

D. W.

A TEXTBOOK OF OBSTETRICS

By Charles B. Reed, M.D., and Bess Cooley, R.N. 476 pp. The C. V. Mosby Company, St. Louis, 1939. $3.

The aim of this book is stated in the Foreword, *i. e.*, " . . to put in concise and uncomplicated form the present-day attitude toward obstetrics as an art and as a science." The authors achieve this aim as they develop in a clear and logical way the various phases of obstetrical care.

Anatomy, physiology, and embryology are reviewed; five of the seventeen chapters are devoted to antepartum care; normal and abnormal labors in the hospital and at home are discussed; and the care of the puerperium and the newborn are handled in detail. Many excellent illustrations are used.

Dr. Reed and Miss Cooley emphasize continually in their book two important points in maternity care. The first of these has to do with the need for asepsis in the examination and care of the genital parts throughout the maternity cycle; the second stresses the need for a close relationship between physician and nurse if adequate obstetrical care is to be provided.

Also it is interesting to note that in this age of bottle-fed infants, Dr. Reed and Miss Cooley emphasize the importance of breast milk.

A Textbook of Obstetrics should prove of value both to the student and the graduate nurse.

MARY B. WILLEFORD, R.N.
San Francisco, California

CLINIC SERVICE IN THE CONTROL OF TUBERCULOSIS

By Jean Downes and A. A. Feller, M.D. 21 pp. Reprinted from *The Milbank Memorial Fund Quarterly*, October 1938.

This analysis of tuberculosis clinic work in the Mulberry Health Center of New York City in 1937 offers classifications and definitions of unusual value to those interested in evaluating such programs. There is much constructive material. The study, however, breaks away from some of the traditional standards and dogma.

The authors emphasize the family aspect of tuberculosis. Families under care are classified according to the condition of the "index case," which is the person constituting the initial reason for tuberculosis supervision. The amount of tuberculosis found in members of the

families according to these classifications shows in which groups close supervision is necessary, and in which ones intensive supervision could be ended.

Re-examination work in relation to the need for it, and the content of the clinic examination—particularly the use of sputum tests and x-rays—are analyzed to point out the quality of clinic services.

The cost of clinic service and the cost per examination are presented according to the type of tuberculosis problem in the family.

D.W.

LANDMARKS IN MEDICINE

Laity Lectures of the New York Academy of Medicine. 347 pp. D. Appleton-Century Company, New York, 1939. $2.

This series of lectures was given by six doctors of medicine and one doctor of philosophy. There is no underlying plan connecting or coördinating the series, and in the three more or less historical essays much of the same ground is covered.

Dr. Raymond Pearl contributes a well planned and excellently presented summary of a number of studies of the factors which contribute to longevity; some new material is included and even statistics and the description of charts appear in palatable form. With the exception of this chapter the lectures lose much when read. Obviously they were planned for presentation by means of the spoken word; in some places the meaning depends on which word is emphasized or in what place a pause is inserted.

The essays contain a number of interesting points for consideration, such as the suggestion that a study of the ailments of the aged might have economic significance through making old people self-sufficient. A plea is made for the substitution of the medical examiner system for the politically appointed coroner in the detection of crime, a matter about which we should all feel great concern. There are also many entertaining discussions, but on the whole the subject matter is too general to interest those who are at all familiar with the field, and the manner of presentation is too haphazard to hold the attention of the completely uninitiated.

The preface states that these lectures were delivered and published in the ". . . spirit of promoting mutual helpfulness and understanding"—an aim which everyone must heartily approve. It is to be hoped that the Academy will continue to work toward this goal, and that as these lectures become an established feature, they will be stepping stones in some definite direction rather than a collection of pebbles of varying size and weight tossed into a pool.

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A STUDY OF PUBLIC HEALTH NURSING SERVICE IN TUBERCULOUS FAMILIES IN THE MULBERRY DISTRICT OF NEW YORK CITY

By Jean Downes and Clara R. Price. 49 pp. Reprinted from *The Milbank Memorial Fund Quarterly*, January 1939, 40 Wall Street, New York.

This study emphasizes again the necessity of concentrating home visits upon the tuberculous families in which the disease is most dangerous and likely to spread. The authors found that the highest prevalence of active, adult pulmonary tuberculosis among contacts occurred in families in which the initial reason for visiting was because of active tuberculosis in the home or because of a recent death from tuberculosis. The lowest incidence was among contacts in which the initial case was a child with a primary infection. Administrators of public health nursing agencies might tabulate the tuberculosis visits during a year according to the seven categories described in this paper to satisfy themselves that their visits are being made where they are most needed.

D. W.

• The second joint conference of the New Jersey, New York, and Philadelphia Industrial Nurses' Clubs and the New England Industrial Nurses' Association was held at the Hotel Statler, Boston, Mass., on October 7. Papers for discussion were given by Mrs. Isabel Poole of the Bigelow-Sanford Carpet Company, New York City, on "Records and Reports"; Anna Rupp of the Teitjen-Lang Drydock Company, Hoboken, N. J., on "Who Should Supervise the Industrial Nurse When There Is No Full Time Physician?"; and Mrs. Elizabeth Dyott of the Insurance Company of North America, Philadelphia, Pa., on "What Can the Industrial Nurse Do to Improve Employer-Employee Relationship?"

At the dinner, Dr. McIver Woody, president of the American Association of Industrial Physicians and Surgeons and medical director of the Standard Oil Company of New Jersey, spoke on "Sickness Among Employees"; and Edwin C. Mayo, president of Gorham Manufacturing Company, Providence, R. I., talked on "Opportunities of the Industrial Nurse for Enlarged Service."

The visiting clubs were the guests of the New England Industrial Nurses' Association at breakfast on October 8 at the Twentieth Century Club, at which time the papers and discussions given at the meeting on the previous day were summarized.

• President Roosevelt has given his approval to the recommendation of the Planning Committee of the White House Conference on Children in a Democracy, which was adopted on October 5, that the Conference to be called into session from January 18 to 20, 1940.

• *Facts About Nursing* has been revised by the Nursing Information Bureau of the American Nurses' Association with the coöperation of the National League of Nursing Education and the National Organization for Public Health Nursing. The 1939 revision, which has thirty more pages than the 1938 edition, contains the latest available statistics about nurses and nursing services. Both nurses and lay people will find it an invaluable reference booklet.

Copies may be ordered from the Nursing Information Bureau, 50 West 50 Street, New York, N.Y., for 25 cents each.

• The New York Association for Improving the Condition of the Poor, usually called the A.I.C.P., has been well known to nurses for many years, because it was unique among family welfare agencies with its staff of 70 public health nurses giving intensive family health service. In this, its ninety-sixth year, the A.I.C.P. has joined hands with the Charity Organization Society of New York (the C.O.S.), an agency of widespread social case-work fame. There has evolved from the two the Community Service Society of New York.

Alta E. Dines and Natalie M. Dodd, the two directors of the educational nursing work, hold the same positions in the merged organization—the largest nonsectarian, private family welfare society in the country. The Nurses' House in Babylon, Long Island—known to hundreds of nurses who have enjoyed its hospitality—continues under Miss Dines' direction.

PUBLIC HEALTH NURSING

DECEMBER 1939

LET MISS JONES FLUFF UP HIS PILLOWS!

That's what the doctors at the hospital always said when there was a particularly grouchy patient—the kind whose thumb stayed married to the bell—Cathy would purr into the patient's ear with that soothing voice of hers, fluff up his pillows with extra care, and first thing you knew he would drop off to sleep, peaceful as a summer afternoon.

The other nurses said it wasn't only the way Cathy Jones* fluffed up pillows—it was also those lovely *hands* of hers. You'd never dream Cathy had them in hard water and strong antiseptics half the day. They always looked white and cool as snowflakes. One day she let the other girls in on her secret.

"I asked myself, 'What did we learn in pharmacology was good for the skin?' and I answered, 'Lanolin—*an emollient closely resembling the oils of the skin itself.*' Then I looked for a hand lotion with lanolin in it, and . . . well, here's the result," she said, fluttering those hands.

What Cathy Used

From this description, it wasn't hard to guess that she meant *Squibb's Hand Lotion*—that delightfully scented, creamy liquid, containing Lanolor (a specially refined *odorless* lanolin). And it wasn't surprising she should find that Squibb's Hand Lotion did so much to keep her hands looking white and smooth. Hands may get red and rough from hard water and harsh antiseptics during the day, but a little Squibb's Hand Lotion at night will counteract the feeling of dryness, help keep them supple and smooth. Use it every morning, too. It forms a long-lasting protective film.

Why not give your hands this soothing —*scientific*—care? Your druggist has Squibb Hand Lotion. Ask for it *today*!

*A fictitious name

Squibb Hand Lotion

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Press of Thomas J. Griffiths Sons, Inc., Utica, N. Y.